The Ohio Bureau of Workers' Compensation

Ohio BWC State Insurance Fund Manual

for Rating Year 2002

(July 1, 2002 – June 30, 2003)

Rating Rules
Premium Rates
Index of Classifications

This is the 2002 **State Insurance Fund Manual**. It has been updated to reflect additions or changes to rules, manual classifications and rates that became effective July 1, 2002.

While the Bureau has made every effort to ensure the accuracy of the information in the State Insurance Fund Manual, the official rules are filed with the Secretary of State and with the Legislative Service Commission. The State Insurance Fund Manual may not be in official rule form and does not contain amendments to rules made subsequent to July 1, 2002.

To receive the 2002 **State Insurance Fund Manual**, please enter complete mailing address (no P.O. Boxes, please) on the reverse side of the post card below. You may also FAX your request to (614) 728-0790 or call **1-800-OHIO-BWC**.

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BWC Programs and Services

BWC programs and services available

Group Rating*
The group-rating plan allows employers who are substantially similar in industry to group together to potentially achieve lower premium rates than they could otherwise achieve as individual employers. Please see Rules 4123-17-61 through 4123-17-68 on pages 81 to 88.

Self-Insurance*
This is a program for large employers with the financial ability to self-insure their operations. Self-insuring employers pay their own workers' compensation claims and pay various assessments to BWC based on the amount of their paid compensation. This program does not apply to public employers. Please see rules 4123-17-32 on page 48, 4123-17-40 on page 50 to 51 and 4123-19-01 through 4123-19-16 on pages 92 to 105.

Retrospective Rating Program*
Retrospective rated employers agree to assume a portion of the risk in exchange for a reduction in premiums. See Rules 4123-17-41 through 4123-17-53 on pages 51 to 56.

Marine Fund Coverage
BWC and private insurers provide this coverage under the Longshore and Harbor Workers Act.

Black Lung Coverage
BWC and private insurers offer this coverage to comply with the requirements of the Federal Coal Mine Health and Safety Act.

$1,000 Medical Only
An enrolled employer may pay up to the first $1,000 of any medical-only claim. These claim costs paid directly by the employer are not included in the employer's experience. Please see Rule 4123-17-59 on pages 79 to 81.

***Information on these programs is available on BWC's Web site: www.ohiobwc.com**

PLEASE SEE REVERSE SIDE FOR ADDITIONAL PROGRAMS

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BWC Programs and Services

BWC programs
BWC doesn't just process claims, but works to prevent them. BWC offers a variety of programs and services to prevent accidents and reduce your workers' compensation costs at no additional fee to you as an Ohio employer. So, take advantage and save. Information on BWC programs and services is available on our Web site at **www.ohiobwc.com** or by calling **1-800-OHIOBWC**. You can learn about BWC's safety programs and materials available in the Safety services section.

Transitional WorkGRANT$ program
BWC's Transitional WorkGRANT$ program provides up to 80 percent of program development costs up to a set amount to qualified employers who implement a transitional work program for their employees. Employers' remaining 20-percent investments can save them thousands of dollars in disability costs and premium impacts. Qualified public and private employers with approximately 500 employees are eligible to receive up to three grants to implement transitional work programs in different departments or divisions of their businesses.

Premium Discount Program + (PDP+)
BWC has redesigned and improved its Premium Discount Program. PDP+ is for employers with up to a .90 experience modification factor. Employers can receive discounts of 10 percent the first year, 10 percent the second year and 5 percent the third year over the three years of the program; plus cash rebates of as much as 20 percent per year for meeting certain safety performance measurements.

Drug-Free Workplace Program (DFWP) and Drug-Free EZ program
DFWP offers private and public state-fund employers premium discounts of between 10 percent and 20 percent for up to five years for establishing a safer and more cost-effective workplace through a substance-free environment. Like DFWP, the Drug-Free EZ program makes it possible for Ohio employers with 25 or fewer employees to receive premium discounts of up to 20 percent for up to five years by implementing a substance-free environment in their workplaces.

***Information on these programs is available on BWC's Web site: www.ohiobwc.com**

PLEASE SEE REVERSE SIDE FOR ADDITIONAL PROGRAMS

Please complete the business reply postcard below to order additional information on any of the above programs.

Please check appropriate boxes next to the programs for which additional information is desired.

- ☐ Drug-Free Workplace Program (DFWP)*
- ☐ Premium Discount Program + (PDP+)*
- ☐ Transitional WorkGRANT$ Program
- ☐ Employer Services
- ☐ Safety & Hygiene Services*
- ☐ SafetyGRANTS*
- ☐ $1,000 Medical Only
- ☐ Black Lung Coverage
- ☐ Group Rating Program*
- ☐ Marine Fund Coverage
- ☐ Retrospective Rating Program*
- ☐ Self-Insurance*

Employer name	Contact person	
Street address		
City	State	ZIP Code
Telephone number ( )	Policy number (found on your Certificate of Coverage)	

BWC

Better Workers' Compensation

Built with *you* in mind.

The Ohio Bureau of Workers' Compensation

Ohio BWC State Insurance Fund Manual

for Rating Year 2002

Rating Rules
Premium Rates
Index of Classifications

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OHIO BUREAU OF WORKERS' COMPENSATION STATE INSURANCE FUND MANUAL

RATING RULES, PREMIUM RATES AND INDEX OF CLASSIFICATIONS

Effective July 1, 2002

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PREFACE

EDITOR'S NOTE: Some of the rules contained in this manual still contain references to the "Workers' Compensation Board." These rules had not been changed at the time of publication. The wording "Workers' Compensation Oversight Commission" is implied in these situations. These rules should be changed in time for the publication of the 2003 State Insurance Fund Manual.

The State Insurance Fund Manual is designed to provide essential information to employers concerning their relationships to the State Fund. The manual contains the rules for rating employers, the rules of procedures for the establishment of coverage, an alphabetical index of employer classifications, a table of current basic rates for each classification and a numerical index of the classifications.

The general rating rules cover such subjects as the premium rates applicable to the employer, eligibility for experience rating, reporting of payroll for premium purposes, premium security deposit, auditing of the employer's records and transfer of coverage from an employer to its successor.

The rules of procedure set forth in the manual state the manner in which an employer establishes workers' compensation coverage in the State Fund.

Ohio law requires that the Bureau of Workers' Compensation classify occupations and industries according to the hazard that they present. Although the number may vary slightly from year to year, there are approximately 216 classifications of hazard. When coverage is established, an underwriter assigns a classification or classifications to the employer according to the type of operation that exists. If the employer later adds to, eliminates from, or changes the nature of operations, it may be necessary to add, eliminate or change one or more of the classifications that are assigned. In the alphabetical index there is an alphabetized listing of employer operations as they are commonly known and there is a reference to the applicable classification of hazard. The classification is identified by a number known as the manual number. Manual numbers are used to simplify reference since a full description would be cumbersome. The premium rates are listed by manual number, and manual numbers are used on the payroll reports. Obviously, the alphabetical list of employer operations cannot be complete in every detail. If you should not find the operation you are seeking, check for it under another common designation. For example, you will not find "filling station" in the alphabetical listing, but you will find "gasoline or oil dealers and drivers".

In the table of premium rates found in the manual there is a numerical listing of the classifications by manual number. The table shows the basic premium rate for each classification. Each year a basic rate for each classification is computed by the bureau using data from the oldest four of the latest five calendar years of loss experience in that classification. The effective date of the annual rate revision is July 1. At that time any changes in the number or type of classification are also made, and any changes in rules are effected.

The Marine Industry Fund and Coal-Workers' Pneumoconiosis Fund (black lung) rates are expressed in their respective rate tables in terms of an amount per $100 of the covered employer's applicable payroll. The rates listed include administrative costs. The Disabled Workers' Relief Fund assessment is not applicable to payroll reported under these two types of coverage. These rates may be adjusted or revised at any time during the year. However, barring unforeseen or extreme circumstances they will likely, for convenience, be revised annually on July 1 concurrent with State Fund (private employer) rates.

Private employer rates are expressed in the rate table in terms of an amount per $100 of the covered employer's applicable payroll. The employer is required to pay assessments for administrative cost and the Disabled Workers' Relief Fund in addition to the premium contribution.

The numerical index of classifications sets forth the types of employer operations that are included in each of the classifications.

Throughout the manual, the term "Not Otherwise Classified" (N.O.C.) is used. The designation indicates that the classification is available for that particular operation only if the operation is not specifically set forth as a part of another classification. For example, commercial-machine shops, not otherwise classified, are assigned manual 3632. Agricultural implement manufacturing in manual 3504 would include the machine shop used in connection with that activity.

Employers are encouraged to present any questions that they may have on the subjects covered in the manual. For inquiries concerning actuarial, call (614) 752-8318. This includes premium rates for classifications.

For inquiries concerning Policy Services matters, call 1-800-OHIO-BWC (644-6292). Policy Services matters include certificates of coverage, classifications, establishment, transfer or cancellation of coverage, out of state employment, payroll reports and premium payments, premium security deposits, remittance and refunds, compliance with the law regarding the payment of premiums, audits, and other account maintenance matters.

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To inquire about an employer's account or to obtain other information, call the following telephone numbers:

Certificates of coverage	Policy Services Department (614) 644-6292 Toll Free: 1-800-OHIO-BWC (644-6292)
Claims information	The nearest customer service office, or the Claims Information Department (614) 644-6292 Toll Free: 1-800-OHIO-BWC (644-6292)
Classifications	The nearest customer service office or the Policy Services Department (614) 644-6292 Toll Free: 1-800-OHIO-BWC (644-6292)
Drug-Free Workplace Program	Risk Special Programs (614) 466-1941
Establishment, transfer or cancellation of coverage	The nearest customer service office or the Policy Services Department (614) 644-6292 Toll Free: 1-800-OHIO-BWC (644-6292)
Experience issues	Risk Technical Services (614) 466-6773
Forms and publications	Office Services Department, Columbus, Ohio (614) 466-4781 Toll Free: 1-800-OHIO-BWC (644-6292)
Group Rating	Risk Technical Services (614) 466-6773
Occupational Safety Loan Program	Division of Safety & Hygiene (614) 995-8622 Toll Free: 1-800-OHIO-BWC (644-6292)
Out of state employment	Policy Services Department (614) 644-6292 Toll Free: 1-800-OHIO-BWC (644-6292)
Premium Discount Program	Risk Technical Services (614) 466-6773
Payroll reports and premium payments	Policy Services Department (614) 644-6292 Toll Free: 1-800-OHIO-BWC (644-6292)
Premium rates	Actuarial Section (614) 752-8318
Premium security deposits	Policy Services Department (614) 644-6292 Toll Free: 1-800-OHIO-BWC (644-6292)
Remittance and refunds	Policy Services Department (614) 644-6292 Toll Free: 1-800-OHIO-BWC (644-6292)
Retrospective Rating	Risk Technical Services (614) 466-6773

Safety & Hygiene assistance	Division of Safety & Hygiene (614) 995-8622 Toll Free: 1-800-OHIO-BWC (644-6292)
Safety & Hygiene Service Office assistance	
Canton	(330) 471-0064
Columbus North	(614) 728-6457
Columbus South	(614) 728-3008
Dayton	(937) 264-5230
Governor's Hill	(513) 583-7085
Independence	(216) 573-7200
Mansfield	(419) 529-7603
Toledo	(419) 327-8988
Warren	(330) 306-4165
Zanesville	(740) 450-5161
Self-Insurance	Self - Insured Department (614) 644-6292 Toll Free: 1-800-OHIO-BWC (644-6292)
Thousand Dollar ($1,000) Medical Only Program	Policy Services Department (614) 644-6292 Toll Free: 1-800-OHIO-BWC (644-6292)

The main office of the Bureau of Workers' Compensation is located at 30 West Spring Street, Columbus, Ohio 43215-2256. The telephone number for general information is (614) 644-6292.

The bureau's state-wide toll-free number is 1-800-OHIO-BWC (1-800-644-6292).

In addition to the central office in Columbus, customer service offices are maintained for the convenience of the public. General information and forms may be obtained at the following customer service offices.

Akron

Ocasek Government Building, 161 S. High St., Suite 300, Akron, Ohio 44308-1617 — **Claims Information** **(330) 643-3111**
Serves Medina, Western Portage, and Summit counties
Ocasek Government Building, 161 S. High St., Suite 403, Akron, Ohio 44308-1617 — **Employer Information** **(330) 643-3075**
Serves Medina, Western Portage and Summit counties.

Bridgeport

56104 National Road, Suite 112, P.O. Box 388-389, Bridgeport, Ohio 43912-0388 — **Claims Information** **(740) 635-1163**
Serves Belmont, Guernsey, Harrison, Jefferson, Monroe and Noble counties. — **Employer Information** **(740) 635-0942**

Canton

400 Third Street S.E., P.O. Box 24801, Canton, Ohio 44701-4801 — **Claims Information** **(330) 438-0638**
Serves Carroll, Holmes, Stark, Tuscarawas and Wayne counties.
400 Third Street S.E., 2nd Floor, Canton, Ohio 44702-1102 — **Employer Information** **(330) 471-0937**
Serves Carroll, Holmes, Stark, Tuscarawas and Wayne counties.

Cincinnati

125 E. Court St., Cincinnati, Ohio 45202-1276 — **Claims Information** **(513) 852-3341**
Serves Brown, Clermont, and Hamilton counties.
Serves Hamilton county. — **Employer Information** **(513) 852-3216**

Cleveland

Frank J. Lausche Building, 615 Superior Ave., 6th Floor, Cleveland, Ohio 44113-1889 — **Claims Information** **(216) 787-3050**
Serves Cuyahoga, Geauga, Lake, and Lorain counties.
Frank J. Lausche Building, 615 Superior Ave., Suite 905, Cleveland, Ohio 44113-1889 — **Employer Information** **(216) 787-3060**
Serves Cuyahoga county.

Columbus-North

30 W. Spring Street, Level 11, Columbus, Ohio 43215-2256 — **Claims Information** **(614) 728-5416**
Serves Franklin county.
30 W. Spring Street, Level 22, Columbus, Ohio 43215-2256 — **Employer Information** **(614) 752-4538**
Serves Franklin county.

Columbus-South

30 W. Spring Street, Level 12, Columbus, Ohio 43215-2256 — **Claims Information** **(614) 466-6446**
Serves Delaware, Fairfield, Fayette, Licking, Madison, Pickaway, Union, and portions of Franklin county.
30 W. Spring Street, Level 22, Columbus, Ohio 43215-2256 — **Employer Information** **(614) 466-8451**
Serves Delaware, Fairfield, Fayette, Licking, Madison, Pickaway, Union and portions of Franklin county.

Dayton

3401 Park Center Dr., Suite 100, P.O.Box 13910, Dayton, Ohio 45413-0910 — **Claims Information** **(937) 264-5000**
Serves Darke, Western Greene, Miami, Montgomery, Preble and Shelby counties.
3401 Park Center Dr., Suite 140, Dayton, Ohio 45414 — **Employer Information** **(937) 264-5217**
Serves Darke, Western Greene, Miami, Montgomery, Preble and Shelby counties.

Governor's Hill

8500 Governor's Hill Drive, Level 4, Cincinnati, Ohio 45249-1389 — **Claims Information** **(513) 583-4400**
Serves Brown, Butler, Clermont, Clinton, Hamilton, and Warren counties.
8500 Governor's Hill Drive, Suite 400, Cincinnati, Ohio 45249-1389 — **Employer Information** **(513) 583-4403**
Serves Brown, Clermont, Clinton, Hamilton, and Warren counties.

Hamilton

One Renaissance Center, 345 High Street, Hamilton, Ohio 45011-6055 — **Claims Information** **(513) 785-4500**
Serves Butler, Hamilton, and Warren counties.
Serves Butler and Hamilton counties. — **Employer Information** **(513) 785-4510**

Independence

5990 West Creek Road, P.O. Box 318030, Suite 200, Independence, Ohio 44131-2167 — **Claims Information** **(216) 573-7700**
Serves Cuyahoga and Lorain counties. — **Employer Information** **(216) 573-7030**

Lima
2025 E. Fourth Street, P.O. Box 780, Lima, Ohio 45804-4101
Serves Allen, Auglaize, Defiance, Hancock, Hardin, Henry, Mercer, Paulding, Putnam, Van Wert and Williams counties.

Claims Information **(419) 227-3127**
Employer Information **(419) 227-4116**

Logan
1225 W. Hunter St., P.O. Box 630, Logan, Ohio 43138-0630
Serves Athens, Fairfield, Hocking, Meigs and Vinton counties.

Claims Information **(740) 385-5607**
Employer Information **(740) 385-9848**

Mansfield
The Tappan Bldg., 240 Tappan Drive, N., P.O. Box 8051, Mansfield, Ohio 44906-8051
Serves Ashland, Crawford, Erie, Huron, Knox, Marion, Morrow, Richland, Seneca, and Wyandot counties.

Claims Information **(419) 747-4090**
Employer Information **(419) 529-4528**

Portsmouth
1005 Fourth Street, P.O. Box 1307, Portsmouth, Ohio 45662-1307
Serves Adams, Gallia, Highland, Jackson, Lawrence, Pike, Ross and Scioto counties.

Claims Information **(740) 353-2187**
Employer Information **(740) 353-3419**

Richmond Heights
26301 Curtiss Wright Parkway, 3rd Floor, Richmond Heights, Ohio 44143-1433
Serves Eastern Cuyahoga, Geauga and Lake counties

Claims Information **(216) 289-4290**

26301 Curtiss Wright Parkway, 3rd Floor, Richmond Hts., Ohio 44143-1433
Serves Cuyahoga, Geauga and Lake counties

Employer Information **(216) 289-5390**

Springfield
1 South Limestone Street, P.O. Box 1467, Springfield, Ohio 45501-1467
Serves Champaign, Clark, Eastern Greene and Logan counties.

Claims Information **(937) 327-1425**

1 South Limestone Street, P.O. Box 1467, Springfield, Ohio 45501-1467
Serves Champaign, Clark, Eastern Greene and Logan counties.

Employer Information **(937) 327-1365**

Toledo
1 Government Center, Suite 1236, P.O. Box 794, Toledo, Ohio 43697-0794
Serves Fulton, Lucas, Ottawa, Sandusky and Wood counties.

Claims Information **(419) 245-2700**

1 Government Center, Suite 1133, P.O.Box 794, Toledo, Ohio 43697-0794
Serves Fulton, Lucas, Ottawa, Sandusky and Wood counties.

Employer Information **(419) 245-2474**

Warren
258 East Market Street, P.O. Box 1190, Warren, Ohio 44482-1190
Serves Ashtabula, Eastern Portage, and Trumbull counties.

Claims Information **(330) 306-4000**
Employer Information **(330) 306-4142**

Youngstown
242 Federal Plaza W., Suite 200, P.O. Box 1877, Youngstown, Ohio 44501-1877
Serves Columbiana and Mahoning counties.

Claims Information **(330) 797-5500**
Employer Information **(330) 797-5011**

Zanesville
905 Zane St., P.O. Box 37, Zanesville, Ohio 43702-0037
Serves Coshocton, Licking, (ZIP Codes 43023, 43025, 43055, 43056 and 43058), Morgan, Muskingum, Perry and Washington counties.

Claims Information **(740) 450-5151**
Employer Information **(740) 450-5260**

Medical Only Claims
30 W. Spring Street, Level 4, Columbus, Ohio 43215-2256
Serves all 88 counties

General Information **(614) 728-6480**

TTY/TDD Ohio Relay Service
Statewide (800) 292-4833

Ombuds Office
Nationwide (800) 335-0996

Ohio Center for Occupational Disease Safety & Health
Local (614) 577-9456
Statewide (800) 533-7723

Industrial Commission of Ohio
30 W Spring Street
Columbus, OH 43266-0581

General Information **(614) 466-6136**
Statewide toll-free **(800) 521-2691**
TTY/TDD **(614) 752-4782**
Statewide toll-free **(800) 686-1589**

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GENERAL RATING RULES

4121-03-31 Waiver for recreational activities
eff. 11/08/86

A. Effective August 22, 1986, an employee who voluntarily participates in an employer's sponsored recreation or fitness program or activity may waive and relinquish all rights to workers' compensation benefits pursuant to division (C)(3) of Section 4123.01 of the Revised Code.
B. This waiver applies to any injury or disability which is incurred while the employee is participating in an employer's sponsored recreation or fitness program or activity.
C. The waiver form must be signed and dated by the employee prior to the date of injury or date of disability in an occupational disease claim. The employee shall receive a personal copy of the signed waiver form. Waiver forms shall be available through the Bureau of Workers' Compensation. An employer desiring an employee waiver shall execute a waiver form, and the executed form shall be valid for two calendar years.

4123-3-34 Settlement of state fund claims.
Eff. 07/12/99

A. The procedures of this rule shall apply to the settlement of state fund injury and occupational disease claims.
B. The employer or the claimant shall file an application for approval of settlement agreement on the appropriate form with the administrator of workers' compensation. Each application shall include the signature of the claimant and the employer, unless the employer is no longer doing business in Ohio.
C. Each settlement application shall:
   1. Include a list of the claim numbers and body parts affected in all claims filed by the claimant with the administrator of workers' compensation or the industrial commission.
   2. Set forth the reason the proposed full and final settlement is deemed desirable by the claimant and state the amount of the requested settlement.
D. Settlement applications filed for lost time claims shall be filed in the service office responsible for processing the claim. Settlement applications for medical only claims shall be filed with the medical claims department.
E. Settlement may be requested for a portion of a claim, one or more claims, or a combination of claims, provided that the claimant is not required to enter into a settlement agreement for every claim that has been filed with the bureau by the claimant.
F. The administrator shall utilize whatever methods the administrator determines to be appropriate, consistent with general insurance principles, to evaluate a claim for settlement. When a settlement agreement has been approved by the administrator, a notice of approval shall be sent to the claimant, the employer, and their representatives, informing them of their rights to withdraw consent to the settlement agreement within thirty days. If written notice of the withdrawal of consent is not filed within the thirty day period, the settlement agreement is final. An injured worker's refusal to endorse a settlement check issued as a result of an agreement reached pursuant to these procedures does not alter the finality of the settlement. The administrator may reopen a settled claim for purposes of conducting a fraud investigation.
G. The administrator shall also send the notice of approval to the industrial commission within five days from the date of the bureau order of approval. The staff hearing officer shall determine, within the time set forth in paragraph (F) of this rule, whether the settlement agreement is or is not a gross miscarriage of justice. If the staff hearing officer determines within that time period that the settlement agreement is clearly unfair, the staff hearing officer shall issue an order disapproving the settlement agreement. If the staff hearing officer determines that the settlement agreement is not clearly unfair, or fails to act within the time limits, the settlement agreement is approved.
H. The effective date of the settlement is the date the notice of approval of settlement agreement is mailed. Once the thirty day waiting period has passed as set forth in paragraphs (F) and (G) of this rule, the agreed settlement shall be final and cannot be appealed to the industrial commission or to court.
I. When a settlement application is filed in a claim in which an application for violation of specific safety requirement has been granted or is pending, the administrator shall refer the claim to the industrial commission for disposition of the application for violation of the specific safety requirement. If the application for the specific safety requirement has been granted and the employer is no longer doing business, or is otherwise not making the payments required by any award for violation of any specific safety requirement, the administrator may approve a final settlement without referring the claim to the industrial commission, provided the administrator identifies any settlement amounts that may be attributed to the award for violation of specific safety requirement. The administrator need not refer to the industrial commission any claim in which the injured worker has voluntarily withdrawn an application for violation of a specific safety requirement, provided no portion of the settlement amount is attributed to any violation of a specific safety requirement.

J. The administrator may offset settlement amounts due the claimant by overpayments owed by the claimant or, where the claimant is also an employer, unpaid premiums owed by a claimant, as the administrator determines appropriate.
K. The representative's signature for either the claimant or the employer satisfies the requirements for paragraphs (B) and (C) of this rule.
L. A settled claim may be used as a defense to a claim for the same or similar conditions. A self-insuring employer shall not settle disabled workers' relief fund liability in state fund claims without the administrator's approval.

4123-3-35 Employer handicap reimbursement.
eff. 07/12/99

A. For the purposes of handicap reimbursement under section 4123.343 of the Revised Code, a "handicapped employee" means an employee who is defined as having one or more of the conditions listed in division (A) of section 4123.343 of the Revised Code.
   1. With respect to the handicap condition defined in division (A)(14) of section 4123.343 of the Revised Code, the employee must have in-patient treatment and admission for the psycho-neurotic disability in a recognized medical or mental institution. Out-patient treatment does not satisfy the statutory definition.
   2. With respect to the handicap condition defined in division (A)(25) of section 4123.343 of the Revised Code, an employer is not eligible for handicap reimbursement in the same claim in which the employee participated in a rehabilitation program. The employee must suffer a subsequent compensable injury or occupational disease claim, and any reimbursement rights would be in the subsequent claim.
B. Under division (B) of section 4123.343 of the Revised Code, the administrator specifies the following grounds upon which the administrator may charge claims costs to the statutory surplus fund.
   1. The administrator will consider handicap reimbursement relief under section 4123.343 of the Revised Code only in claims satisfying all of the following prerequisites:
      (a) The claimant is a handicapped employee as defined in division (A) of section 4123.343 of the Revised Code and paragraph (A) of this rule.
      (b) The employer has filed an application for handicapped reimbursement while the claim is within the employer's claim experience period, as referred to in division (B) of section 4123.34 of the Revised Code.
         (i) For a claim involving a private state fund employer, the application shall be filed by June 30 of the year no more than six years from the year of the date of the injury or occupational disease.
         (ii) For a claim involving a public employer taxing district employer, the application shall be filed by December 31 of the year no more than five years from the year of the date of the injury or occupational disease.
         (iii) For a claim involving a self-insuring employer that has elected to continue to participate in the handicap reimbursement program, the application shall be filed as provided in paragraph (G) of this rule.
      (c) The bureau has awarded compensation to the claimant for temporary total disability, disabilities described under division (B) of section 4123.57 of the Revised Code, permanent total disability, or death benefits, or the claimant has received wages from the employer in lieu of compensation.
   2. For an employer granted relief, all or such portion as the administrator determines of the amount that otherwise would be charged to the employer's experience will be deducted from each claim arising from injury or occupational disease to a handicapped employee for the purpose of premium or assessment adjustment, in accordance with the following principles and paragraphs (E), (F), and (G) of this rule:
      (a) All amounts deducted from the experience of the employer will be charged to the statutory surplus fund.
      (b) The bureau will calculate the amount of the cost of the claim to remain in the employer's experience by applying the complement of the handicap percentage to the reducible costs contained within the claim cost as limited by the maximum value of a claim chargeable to the employer's experience, as determined by the employer's credibility group under rule 4123-17-05 of the Administrative Code.
      (c) The bureau will apply the handicap reimbursement in a claim to only the following claims awards and reserves:
         (i) temporary total disability;
         (ii) disabilities described under division (B) of section 4123.57 of the Revised Code;
         (iii) permanent total disability;
         (iv) death benefits;
         (v) medical payments; and
         (vi) claims reserves.
      (d) If the actual cost of a claim exceeds the maximum value of the claim chargeable to a particular employer's

experience, the ratio of the nonreducible costs of the claim to the total cost of the claim shall be maintained in the maximum value chargeable to the particular employer's experience, so that when the handicap percentage is applied, it will be applied only to that portion of the maximum value that is reducible in accordance with division (B) of section 4123.343 of the Revised Code.

(e) Any agreement between an employer and the claimant as to the merits of a claim or the amount of the charge to the statutory surplus fund shall forfeit any rights of the employer to any handicap reimbursement under this rule. This provision does not apply to the employer's certification of the claim.

C. The administrator of workers' compensation may delegate the authority granted to the administrator under chapters 4121. and 4123. of the Revised Code for determining the amount an employer may be reimbursed from the statutory surplus fund in connection with the employer's handicapped employees under this rule. The decision of the administrator's designee shall be the decision of the administrator.

1. An employer which seeks a handicap reimbursement award must file a complete and timely application and attach copies of all relevant medical evidence which the employer believes the administrator should consider when determining the appropriate award.
   (a) The administrator may dismiss without prejudice an incomplete application. The administrator may dismiss without prejudice an application at the employer's request. Within the time limits and provisions of this rule the employer may refile an application that was dismissed without prejudice.
   (b) The administrator may deny an application not filed within the employer's experience as provided in division (B) of section 4123.34 of the Revised Code and paragraph (B)(1)(b) of this rule.
   (c) The administrator may dismiss an application which fails to meet the jurisdictional requirements of paragraphs (A) and (B) of this rule.
2. The administrator may issue a handicap reimbursement order based on a review of the application and any information contained in any relevant claim file or any other relevant bureau or Industrial Commission records.
3. The administrator shall afford an employer the opportunity for an informal conference if the application meets the jurisdictional requirements of this rule.
   (a) If the administrator conducts an informal conference, the administrator shall mail a notice of conference to the employer and its representative by regular mail, setting forth the date, time, and place of the conference.
   (b) The administrator shall notify the employer by mail not less than fourteen days before the date of such conference, unless the employer waives this requirement.
   (c) At the request of the employer or another party, the administrator may conduct an expedited or an informal telephone conference.
4. The administrator's decision shall be reduced to writing, signed, and mailed to all interested parties. The order shall state the evidence upon which the administrator based the decision.
5. The administrator shall keep a record of handicap applications received, conferences scheduled, orders issued with publication dates and any waiver of appeals, and appeals to the Industrial Commission.

D. The burden of proof is upon the employer to establish entitlement to the relief under section 4123.343 of the Revised Code by appropriate medical evidence or other evidence as may be indicated

1. With respect to any credit under division (D)(1) of section 4123.343 of the Revised Code, the administrator shall grant full handicap credit if the employer establishes that the injury or occupational disease would not have occurred but for the employee's pre-existing handicap condition.
2. With respect to any credit under division (D)(2) of section 4123.343 of the Revised Code, the administrator shall determine the degree of relief to be granted based upon the following:
   (a) The degree to which medical evidence indicates the pre-existing handicap has affected the cost of the claim.
   (b) The employer shall establish the relationship between the pre-existing condition and subsequent injury by way of aggravation or delayed recovery by proof on file but the condition need not be recognized by an order of allowance for such condition or aggravation of the condition.
   (c) In determining the appropriate per cent of relief in the claim, the administrator shall consider the effect of the handicap condition on the past claims costs and shall also account for the effect of the handicap condition on the anticipated future costs of the claim.

E. A non-complying employer shall not be entitled to relief under section 4123.343 of the Revised Code. If the employer had active coverage on the date of the injury but the coverage was lapsed or canceled on the date of the application or hearing, the employer is entitled to a determination of handicap relief under section 4123.343 of the Revised Code.

F. No employer shall in any rating year receive credit under section 4123.343 of the Revised Code in an amount greater than the premium it paid if a state fund employer or greater than its handicap assessment if a self-insuring

employer.

G. The administrator shall reimburse a self-insuring employer in the same manner as a state fund employer, except that reimbursement shall be made by direct payment to the self-insurer from the statutory surplus fund.
   1. The self-insuring employer shall file an application for handicap reimbursement within five years from the date of injury or within five years from the beginning of disability in an occupational disease claim.
   2. A self-insuring employer may, for all claims filed after January 1, 1987, elect to pay compensation and benefits directly under this rule and shall receive no money or credit from the surplus fund for the payments under this rule, nor shall the employer be required to pay any amounts into the surplus fund that otherwise would be assessed for handicap reimbursement for claims filed after January 1, 1987. A self-insuring employer which makes such election also shall assume responsibility for compensation and benefits paid directly under this rule for all claims filed prior to January 1, 1987, and shall not be required to pay any amounts into the surplus fund by reason of this rule and may not receive any money or credit from that fund on account of this rule.
   3. A self-insured employer that has elected to remain in the handicap reimbursement program and has been granted handicap relief shall submit a request for direct reimbursement to the bureau's self-insured department on the form designated for reimbursement.

H. An order issued by the administrator is appealable under section 4123.511 of the Revised Code.
   1. If the administrator holds an informal conference, the employer and the administrator may agree upon the amount of the handicap reimbursement in a claim, and the employer may waive its right to appeal.
   2. Upon waiver of the employer's right to an appeal or the expiration of the appeal period, the administrator's order is final, and the bureau will immediately process the award.
   3. If no agreement is reached at the informal conference and the employer files a written appeal within fourteen days of the employer's receipt of the administrator's decision, the administrator shall forward the claim file to the Industrial Commission within seven days of the administrator's receipt of the notice of appeal for a hearing before a district hearing officer.
   4. The employer and the administrator are parties at any hearing conducted by the Industrial Commission or its hearing officers.
   5. Upon a final Industrial Commission order which grants handicap relief, the bureau will immediately process the award.

I. Since pursuant to paragraph (D)(2)(c) of this rule the administrator shall consider the effect of the handicap condition on the past and future costs of the claim in determining the handicap relief, the employer is not entitled to consideration of a subsequent application for handicap relief for a condition in a claim in which the administrator has made a previous determination on the condition, regardless of whether there has been a change in circumstances such as allowance of the condition or payment of compensation. A subsequent application shall not substitute for an appeal of the administrator's order. The administrator shall dismiss or deny any subsequent application for an increase in handicap relief in a previously determined claim.

Rule replaces: 4121-3-28

4123-3-36 Immedite allowance and payment of medical bills in claims
eff. 12/17.01

A. Pursuant to section three of Sub. H.B. 75 of the 124th General Assembly, the administrator, with the advice and consent of the workers' compensation oversight commission, hereby adopts this rule to identify specified medical conditions for which the administrator may grant immediate allowance and immediate payment in accordance with this rule.

B. The administrator shall establish a pilot program to determine the effectiveness of the immediate allowance of medical conditions under this rule. The pilot program and this rule shall be effective through April 10, 2004, at which time the bureau shall terminate the pilot program and the rule shall cease to be effective.

C. The administrator shall identify specific medical conditions that have a historical record of being allowed whenever included in a claim.
   1. The administrator may identify these medical conditions by ICD code or other method of designation.
   2. The administration may use historical statistical criteria to determine the appropriate specific medical conditions to include in the pilot program under this rule. The criteria may include, but are not limited to the following:
      a. Number of claims for the medical condition;
      b. Percent of claims for the medical condition disputed;

c. Percent of claims for the medical condition appealed;
d. Percent of claims for the medical condition disallowed; and
e. Average cost for the medical condition per claim.

3. The medical conditions that the administrator determines are to be included in the pilot program under this rule are attached as Appendix A, ICD Code and Description.

D. Upon the initial filing of a claim, the administrator shall investigate the claim and issue an order on the claim as required by section 4123.511 of the Revised Code. The administrator shall consider all necessary evidence and relevant laws and rules for the determination of the allowance of a claim. For any medical condition identified in Appendix A of this rule, however, the administrator may grant immediate allowance of the medical condition and may make immediate payment of the medical bills relating to that condition, regardless of the receipt of the medical reports for that medical condition or the employer's certification of the claim.

E. The employer retains the right to contest the immediate allowance and payment of the medical condition in a claim under this rule. If the employer appeals the allowance and payment and the claim is disallowed, the payment for the medical treatment provided prior to the date of the disallowance of that claim shall be charged to and paid from the surplus fund created under section 4123.34 of the Revised Code. The administrator shall not seek reimbursement of the payment from the injured worker or the provider.

Appendix A
ICD CODE AND DESCRIPTION

ICD Code	ICD Description	ICD Code	ICD Description
692.72	Solar dermatitis nec	945.19	1st deg burn leg-mult
872.02	Opn wound auditory cannal	877.0	Opn wound buttock
872.69	Opn wound of ear nec	940.1	Burn periocular area nec
873.21	Opn wound nalsal septium	941.12	1st deb bun eye
873.22	Opn wound nasal cavity	872.01	Opn wound of auricle
873.65	Opn wound of palate	843.12	1st deg burb elbow
878.0	Opn wound of penis	941.11	1st deb burn ear
878.4	Opn wound of vulva	883.0	Opn wound offinger
878.8	Opn wound gential nec	944.14	1st burn finger w thumb
879.4	Opn wound lateral abdomen	942.12	1st deg burn chest wall
879.6	Opn wound of trunk nec	881.00	Opn wound of forearm
880.01	Opn wound of scapula	879.2	Opn wnd anterior abdomen
880.02	Opn wound of axilla	881.02	Open wound of wrist
922.33	Contusion of interscapular region	918.0	Superfic inj eyelids
930.2	Fb in lacrimal punctum	944.15	1st deg burn palm
940.3	Acid burn cornea/conjunc	882.0	Open wound of hand
941.13	1st deg burn lip	914.6	Foreign body hand
941.14	1st deg burn chin	873.44	Open wound of jaw
941.16	1st deg burn scalp	921.3	Contusion of eyeball
942.10	1st deg burn trunk nos	913.6	Foreign body forearm
942.19	1st deg burn trunk nec	873.64	Opn wind tongue/mouth flr
943.14	1st deg burn axilla	930.0	Corneal foreign body
943.15	1st deg burn shoulder	930.1	Fb in conjuctival sac
943.19	1st deg burn arm-mult	890.0	Open wound of hip/thigh
945.11	1st deg burn toe		

4123-14-01 Noncomplying employers within the meaning of the law
eff. 02/22/90

An employer, as defined in Division B of Section 4123.01 of the Revised Code, who either fails to establish industrial coverage and make payments of premiums to the State Insurance Fund, as required by Chapter 4123. of the Revised Code and the rules of Industrial Commission and the Bureau of Workers' Compensation, or fails to comply with the requirements for Self-Insurance under Section 4123.35 of the Revised Code and the rules of the Industrial Commission or Bureau of Workers' Compensation, shall be regarded as a noncomplying employer.

4123-14-02 Procedures for the collection of premiums from noncomplying employers
eff. 12/14/92

A. Whenever the Bureau of Workers' Compensation finds that an employer who was subject to division (B)(2) of Section 4123.01 of the Revised Code failed to comply with the law in matters of industrial coverage, the bureau shall forthwith notify said employer in writing of such a finding. The notice shall outline the period(s) of time during which the employer was an amenable employer, and further, it shall specify that the employer has twenty days from the receipt of the notice to furnish the Bureau of Workers' Compensation with the appropriate payroll report and pay the applicable premium, as required by law.
B. Where the employer is not a resident of the State of Ohio, or conceals its whereabouts or its whereabouts are unknown and cannot be ascertained, and no forwarding address can be found, or where the employer is deceased, the service of process shall be made in accordance with Sections 4123.751 to 4123.756 of the Revised Code.
C. If the employer does not furnish the required payroll report and does not pay to the State Insurance Fund the applicable premium and/or the premium security deposit within the twenty-day period referred to in Paragraph (A) of this rule, the Bureau of Workers' Compensation shall immediately take the following action:
   1. Make an assessment of the premium due from the employer, in accordance with Sections 4123.32 and 4123.37 of the Revised Code and rule 4123-19-07 of the Administrative Code. The assessment shall be based on such information as may be in the possession of the Bureau of Workers' Compensation.
   2. Under the authority of Section 4123.78 of the Revised Code, file with the county recorder of any counties in which such employer's property may be located a certificate of the amount of premium(s) due from such an employer and the amount so due shall be a lien from the date of such filing against the real and personal property of the employer within the county in which such certificate is filed.
D. The Bureau of Workers' Compensation shall forthwith give to the employer a written notice of any action taken. The notice shall be mailed to the employer at its residence or usual place of business by certified mail with return receipt requested or as provided in paragraph (B) of this rule. Furthermore, the notice shall inform the employer that unless it files with the Bureau of Workers' Compensation, within twenty days after receipt of said notice, a petition for reassessment in writing, verified under oath by said employer, or its authorized agent having knowledge of the facts, setting forth in detail the items of the assessment objected to and the reason(s) for the objection, such assessment shall become final and the amount thereof shall be due and payable from the employer so assessed to the State Insurance Fund.
E. In the event a petition objecting to the assessment is duly filed by the employer, the matter shall be referred to the Administrator of the Bureau of Workers' Compensation, who may refer the matter to be set for hearing before the Bureau of Workers' Compensation Adjudicating Committee. The notice of hearing shall be mailed to the petitioner by certified mail and to its representative, setting forth the date, time and place of hearing. It will be mailed to the parties, as indicated above, not less that fourteen days before the date of such a hearing. In justifiable cases an emergency hearing may be arranged.
F. A copy of the finding and order of the Administrator shall be mailed by certified mail to the party assessed and by regular mail to the representative of such a party.
G. If it is the order of the Administrator that the employer pay the assessment, payment shall become due ten days after the notice of the finding and order of the Administrator was mailed to such employer.
H. The employer has the right to appeal the decision of the Administrator to the Court of Common Pleas of Franklin County upon the execution of a bond to the state in double the amount due and ordered paid by the bureau, upon the condition that the employer will pay any judgment and costs rendered against it for the premium(s), as provided in Section 4123.37 of the Revised Code.
I. When no petition objecting to the assessment is filed or when a finding is made affirming or modifying such an assessment after hearing, a certified copy of the assessment, as affirmed or modified, shall be filed by the Bureau of Workers' Compensation, not later than twenty days from the date the order has become final, with the clerk

of the Common Pleas Court in any county in which the employer has property or in which the employer has a place of business, for the purpose of obtaining a judgment for the state against the employer in the amount shown on the assessment. As soon as the judgment is rendered, proper action shall be taken to levy execution on said judgment.

J. However, an assessment or judgment, as outlined in the preceding paragraphs of this rule, shall not be a bar to the adjustment of the employer's account upon the employer furnishing his payroll records to the bureau.

K. In addition to the procedures outlined in paragraphs (A) to (I) of this rule, the Administrator of the Bureau of Workers' Compensation shall, in justifiable cases, certify the matter to the Attorney General's office with a request that the employer be enjoined from further operation in accordance with Section 4123.79 of the Revised Code and/or that criminal proceedings be instituted against the employer for penalties under Division (C) of Section 4123.99 of the Revised Code. Furthermore, in cases where the employer failed to furnish to the Bureau of Workers' Compensation the annual payroll report and other related information required by Section 4123.26 of the Revised Code, a civil action shall be brought against such employer in the name of the state to collect the penalty, as provided in that Section.

L. For counties and public employer taxing districts, the bureau shall keep an individual account showing the amount of money paid into the public insurance fund and the amount of losses incurred against the fund. When any such employer defaults in the payment of sums required to be contributed to such fund or any official fails to perform any act required to be performed in reference to the making of payments, the bureau shall institute the proper proceedings in court to compel such payment.

4123-14-03 Requests for waiver of a default in the payment of premium for approval of the original industrial coverage retroactively, and for abatement of penalties

eff. 02/22/90

A. The Administrator of the Bureau of Workers' Compensation, for good cause shown, may:
   1. Waive a default in the payment of premium by an employer whose industrial coverage has lapsed, if such a default is of less than sixty days duration, if such a waiver is granted, industrial coverage shall be reinstated retroactively.
   2. Approve the original industrial coverage to take effect retroactively.
   3. Abate penalties imposed on employers for failure to comply with the Ohio Bureau of Workers' Compensation statute.

B. The term "good cause," as used in paragraph (A)(1) of this rule, means a substantial reason, one that affords a legal justification or a legal excuse.

C. Such requests shall be in writing. They shall be properly signed in handwriting by the employer concerned or by its duly authorized representative. The reason(s) for the relief sought shall be fully explained. Unsigned requests shall be held in abeyance until they are properly completed, and the applicant shall be notified accordingly.

D. The Administrator may refer such requests to the adjudicating committee, established by the Administrator of the Bureau of Workers' Compensation, for further consideration and for the determination of the issue(s) raised.

4123-14-04 Procedures to recover from a noncomplying employer the amount of money paid out of the State Insurance Fund for an industrial injury, occupational disease and/or death

eff. 02/22/90

A. Upon the filing of an industrial claim, naming a noncomplying employer as the employer, and as soon as the claim has been numbered and recorded by the Bureau of Workers' Compensation, the bureau shall prepare and, by certified mail, file for record in the office of the county recorder in the counties where the employer's property is located, if known, or in the county (or counties) where the employer's business is located, an affidavit showing the date on which the application for compensation and/or benefits was filed, the name and address of the employer against whom it was filed, and the fact that said employer has not complied with Section 4123.35 of the Revised Code. A copy of the application for compensation and/or benefits shall be filed with the affidavit. The affidavit shall constitute a lien on employer's real property and tangible personal property within the county where it was filed.

B. The bureau shall notify the employer, within the shortest time possible, of the filing of the application, which notice shall be mailed by certified mail. Such notice shall be accompanied by a copy of the application and a copy of the affidavit, as described in paragraph (A) of this rule, and shall advise the employer that unless it files a timely answer to the application, as required by Rules 4121-03-14 and 4123-03-14 of the Administrative Code, the claim shall be adjudicated upon the application that has been filed.

C. The lien on employer's property, as described in paragraph (A) of this rule, shall be cancelled under the following circumstances:

1. The employer has paid the amount of all awards made by the commission and/or the bureau;
2. There was a final order of disallowance of claim(s);
3. The employer has filed a bond or other security in such an amount and with such a surety as the bureau approves, conditioned on the employer's payment of all awards made by the commission and/or the bureau. The bureau may, in its discretion, grant a partial release of the lien, should this be necessary to facilitate the conduct of the employer's business provided a sufficient security remains to pay any award that may be made in the claim or claims.
4. Settlement of employer's liability as provided in Rule 4123-14-05 of the Administrative Code.

D. In all cases of employer's failure to pay the award(s) of compensation and/or benefits, as approved by the commission and/or the bureau, or to furnish a satisfactory bond within ten days after notification of such award(s), payment of the award(s) from the surplus fund and the recovery of the monies so paid by the bureau shall be in accordance with Section 4123.75 of the Revised Code.

E. The award(s) of compensation and/or benefits, referred to in paragraph (D) of this rule, shall constitute a liquidated claim for damages against the noncomplying employer. The bureau shall certify the record to the Attorney General to institute a civil action against the employer for collection of the award(s). Such action may be joined with the action to recover premium(s) due from such employer.

4123-14-05 Settlement of liability of a noncomplying employer
eff. 02/22/90

A. A noncomplying employer may apply to the Administrator of the Bureau of Workers' Compensation for settlement of its liability to the State Insurance Fund. The request shall:
   1. Be in writing and properly signed in handwriting by the employer concerned or by its duly authorized representative. Unsigned requests shall be held in abeyance until properly completed, and the applicant shall be notified accordingly;
   2. Clearly set forth the circumstances by reason of which the proposed settlement is deemed desirable;
   3. Include, but not be limited to, the following information:
      a. The size of employer's business - number of employees;
      b. The location of the business (Ohio, other states, etc.);
      c. The length of time the employer has been in business;
      d. The nature and type of employer's business for the past five years;
      e. A copy of the employer's federal and state income tax return for the past three years.
      f. A notarized financial statement of current assets and liabilities;
      g. A sworn statement to explain the reason for non-compliance with the "Ohio Workers' Compensation Act";
      h. The amount of the requested settlement;
      i. Is the employer in business at the present time and complying with the "Ohio Workers' Compensation Act."

B. The Administrator may refer the request to the law section of the Bureau of Workers' Compensation for review, preparation of memorandum, and presentation to the adjudicating committee for approval or disapproval of the offer of settlement. The employer's past history with the bureau, if any, as reflected by the records of the bureau or commission, shall be checked and verified. If additional information is needed for proper disposition of the case, the matter may be referred for investigation. In justifiable cases an independent financial statement and employer's credit rating may be obtained.

C. The adjudicating committee may accept the offer of settlement if it finds from a preponderance of the evidence that such a settlement shall be:
   1. In the best interest of the State Insurance Fund; or
   2. In the best interest of the employees of the employer concerned; or
   3. That it will be beneficial to the general welfare of the community; or
   4. That it will best serve any other public purpose.

The decision of the adjudicating committee shall be reduced to writing and shall be mailed forthwith to all interested parties.

4123-14-06 Bureau of Workers' Compensation Adjudicating Committee
eff. 10/14/02

A. The Administrator of the Bureau of Workers' Compensation may delegate the authority granted to the administrator under Chapters 4121., 4123. and 4131. of the Revised Code and Chapter 4123 of the Administrative Code for determining employer premium, assessment, or penalty obligations or liabilities,

eligibility for alternative premium plans or discount programs or other employer-related disputes or issues as may be authorized under the workers' compensation statutes and rules. For this purpose, the Administrator may appoint an adjudicating committee to provide employers with hearings on such matters referred to the committee.

1. An employer shall file with the bureau a request, protest, or petition of a premium, assessment, or penalty obligation or liability, or an application for an alternative premium plan or discount program within the time limit established by the appropriate section of the Revised Code or rule of the Administrative Code for such matter.
2. The bureau shall notify the employer in writing of its determination on the employer's request, protest, petition, or application.
3. Unless a different time is provided by the Revised Code or the Administrative Code for such matter, an employer shall file a protest or appeal of the bureau's decision on the request, protest, petition or within two (2) years of receipt of the bureau's determination.
4. The employer shall state the specific grounds or reasons for the protest or appeal of the bureau's determination, and shall include supporting documentation. The bureau may refuse to grant a hearing to the employer where the employer has failed to state the specific grounds or reasons for the protest or appeal or has failed to provide supporting documentation as required by this rule.
5. For the purpose of hearing the protest or appeal, the administrator may appoint an adjudicating committee to provide employers with hearings on such matters referred to the committee.

B. The adjudicating committee shall consist of three members appointed by the Administrator. The members shall consist of persons who shall have expertise or experience in matters relating to employers.

C. The adjudicating committee shall hold meetings and hearings to determine matters referred to it by the administrator for adjudication. With the approval of the administrator, the committee members amy delegate alternate bureau employees to act on their behalf. The committee may issue decisions without formal hearing, but shall afford an employer the opportunity for a formal hearing before the committee upon request. A prompt, efficient, and expeditious determination of matters coming before the committee shall be ensured to protect the interest of employers and the State Insurance Fund.

D. If an employer requests a hearing before the adjudicating committee or the committee determines that a hearing is in the best interest of the employer or the State Insurance Fund, the committee shall mail a notice of hearing to the employer and its representatives by regular mail, setting forth the date, time and place of the hearing. The notice shall be mailed not less than fourteen days before the date of such hearing. In justifiable cases, an emergency hearing may be arranged with the adjudicating committee.

E. The committee shall keep a record of its dockets and proceedings. The committee's decision shall be reduced to writing and mailed forthwith to all interested parties and shall state the evidence upon which the decision was based and the reasons for the committee's actions. The decision of the committee shall be the decision of the Administrator. If the employer files a written appeal within thirty days of the employer's receipt of the committee's decision, the administrator or the administrator's designee shall hear the appeal of the decision of the committee, and shall conduct a hearing for such purpose.

F. The Administrator may authorize the adjudicating committee to consider the following matters:

1. Requests for waiver of a default in the payment of a premium under Section 4123.37 of the Revised Code;
2. Requests for settlement of liability of a noncomplying employer under Section 4123.75 of the Revised Code;
3. Petitions objecting to assessment of premium under Rule 4123-14-02 of the Administrative Code and Section 4123.37 of the Revised Code;
4. Employer's request for abatement of penalties under Rule 4123-09-07 of the Administrative Code and Section 4123.32 of the Revised Code;
5. Protests of audit findings, manual classifications, experience ratings, retrospective ratings, or transfers or combinations of risk experience;
6. Any other risk or premium matters as authorized and delegated by the Administrator under Chapters 4121., 4123. and 4131. of the Revised Code.

4123-17-01 Annual rate revision, method of adoption, effective date, publication
eff. 9/1/93

A. Private employers.

1. The annual revision of premium rates, as provided in division (B) of Section 4123.34 of the Revised Code, shall apply to all renewals, reinstatements and new coverage effective on or after July first of each year, unless otherwise specifically provided. At the same time the Bureau of Workers' Compensation may adopt such changes in classification of occupations or industries with respect to their degree of hazard as will best serve to determine the risks of the different classes of occupations and will enable the establishing of

appropriate premium rates measured by the hazard involved.

2. The revised premium rates and changes in classification of occupations or industries with respect to their degree of hazard, as provided in paragraph (A)(1) of this rule, shall be adopted by rules recommended by the Administrator and approved by the Workers' Compensation Board as provided under Division (J) of Section 4121.12 of the Revised Code.
3. The rules, with the revised premium rates and changes in classification of occupations or industries (if any) attached thereto, shall be filed with the Secretary of State and Legislative Service Commission as provided under Section 111.15 of the Revised Code. The revised rates and changes in classifications (if any) shall become effective on the date indicated on the filed rule, generally no sooner than ten days from the date of the filing of the rule.
4. The revised premium rates and changes in classification of occupations or industries (if any) shall be annually published in the Ohio Workers' Compensation Insurance Fund Manual. The manual shall contain a complete index of classifications of industries, arranged in alphabetical and in numerical order, as well as a complete list of basic premium rates and expected loss rates.

B. Public employers, taxing districts.
   1. The annual revision of premium rates for the taxing districts, as provided in Section 4123.39 of the Revised Code, shall apply to all renewals, reinstatements and new coverage effective on or after January first of each year, unless otherwise specifically provided.
   2. The revised premium rates as provided in paragraph (B)(1) of this rule, shall be adopted by rules recommended by the Administrator and approved by the Workers' Compensation Board as provided under Division (J) of Section 4121.12 of the Revised Code.
   3. The rule with the revised premium rates shall be filed with the Secretary of State and the Legislative Service Commission as provided under Section 111.15 of the Revised Code. The revised rates shall become effective on the dated indicated on the filed rule, generally no sooner than ten days from the date of the filing of the rule.
C. Public employers, state of Ohio, its agencies and instrumentalities.
   1. The annual revision of premium rates, including all renewals, reinstatements and new coverage for the state of Ohio, its agencies and instrumentalities, as provided in Section 4123.40 of the Revised Code, for all state agencies shall be effective July first of each year.
   2. The revised premium rates as provided in paragraph (C)(1) of this rule shall be adopted by rules recommended by the Administrator and approved by the Workers' Compensation Board as provided under Division (J) of Section 4121.12 of the Revised Code.
   3. The rule with the revised premium rates shall be filed with the Secretary of State and the Legislative Service Commission as provided under Section 111.15 of the Revised Code. The revised rates shall become effective on the date indicated on the filed rule, generally no sooner than ten days from the date of the filing of the rule.

4123-17-02 Basic or manual rate
eff. 01/27/97

A. The "basic or manual" rate is hereby expressed as the unit of premium per one hundred dollars of payroll for accident and disease coverage.
B. Succeeding employers - experience.
   1. Where one legal entity, not having coverage in the most recent experience period, wholly succeeds another legal entity in the operation of a business, his or its rate shall be based on the predecessor's experience within the most recent experience period.
   2. Where a legal entity wholly succeeds one or more legal entities and all are operating at the basic rate, the basic rate shall apply to the succeeding entity.
   3. Where a legal entity having an established coverage or having had experience in the most recent experience period wholly succeeds one or more legal entities having established coverage or having had experience in the most recent experience period and at least one of the entities involved has a merit rating experience, the experience of all the involved entities shall be combined to establish the rate of the successor.
   4. Where a legal entity succeeds in the operation of a portion of a business of one or more legal entities having an established coverage or having had experience in the most recent experience period, the successor's rate shall be based on the predecessor's experience within the most recent experience period, pertaining to the portion of the business acquired by the successor.
      Pursuant to this rule, the bureau shall provide to the parties to the transfer of experience the necessary forms and instructions to complete the transfer of the appropriate payrolls and claims. Each party to the transfer

of experience shall sign the completed forms. The bureau shall review the completed forms and if any questions arise, the bureau may conduct a premium audit on each party's risk account.

5. When any combination or transfer of experience is indicated under any of the provisions of this rule, the effective date of such combination or transfer shall be the beginning date of the next following payroll reporting period. In cases where an entity not having coverage wholly succeeds another entity, the experience of the predecessor shall be transferred to the successor-employer effective as of the actual date of succession.

C. Succeeding employers - - risk coverage transfer.
   1. Transfer of active risk coverage shall be effective only when an agreement between the predecessor and the successor to transfer is filed with the bureau .
   2. When an active risk coverage is transferred, the successor shall assume the predecessor's obligations under the workers' compensation law and shall be credited with any existing premium credits including advance premium security deposit of the predecessor.
   3. Transfer of an active risk coverage may be retroactive to the date of succession.
   4. The successor to an active risk must preserve the predecessor's payroll records for at least five years prior to the date of transfer.
   5. A legal entity may be assigned only one risk. Where a legal entity succeeds one or more risks, he or it shall be assigned a single risk designation.

4123-17-03 Employer's classification rates
eff. 07/1/02

A. An employer's premium rates shall be the manual basic rates as provided under rules 4123-17-02, 4123-17-06, and 4123-17-34 of the Administrative Code for each of its classifications except as modified by its experience rating, and shall apply for the first two six-month periods beginning on or after the first of July for private employers and shall apply for the calendar year beginning on or after the first of January for public employer taxing districts.
   1. In calculating the manual base rate under this rule, the bureau shall exclude the experience of an employer that is no longer active if the inclusion of the inactive employer's experience would have a significant negative impact upon the remaining active employers in a particular manual classification.
   2. The calculation of the base rate and the experience rate shall be applied to all employers reporting payroll in the manual classification, whether or not the premiums of the individual employers are reduced.
   3. Once the bureau has determined that the loss data of a specific inactive employer shall be removed from the manual classification experience, the bureau shall exclude the data of that employer from all future manual classification rate calculations. If that inactive employer reactivates its account with the Ohio state insurance fund, the bureau shall include the loss data in rate calculations for the manual classification.
   4. As used in this rule an employer that is "no longer active" or is "inactive" is defined as an employer that satisfies all of the following criteria:
      a. The employer is assigned the policy status "bankrupt cancel," "cancel effective date," "final cancel," "cancelled uncollectible," "no coverage due to claim," or "no coverage;"
      b. The employer is not reporting payroll;
      c. The employer is not paying premiums or assessments to the Ohio state insurance fund as of the rate cut off date under either its own identity, the identity of any successor entity, or as a self-insured entity; and
      d. The employer does not employ employees for which Ohio workers' compensation jurisdiction would apply.
   5. As used in this rule, a "significant negative impact" is defined as occurring when the inactive employers in the manual reported forty percent or more of the payroll in the manual classification in any calendar year in the experience period and when the loss rate and loss/premium ratio of the inactive employers taken as a whole are significantly higher than those of the active employers taken as a whole as measured using the data from the prior policy year's most current four years data. For private employer rates effective July 1, 1997, the bureau shall use the experience period data of the current policy year.

B. An experience-rated employer's manual classification rate modification (credit or penalty) shall be determined by multiplying its experience modification percentage (EM%) times the basic manual rate for each assigned manual classification. The amount of the modification shall then be subtracted from or added to the respective basic rate to obtain the employer's premium rate for each classification.

C. The experience modification percentage (EM%) shall be determined on the basis of the employer's experience and applied to the basic rate. The experience modification percentage of the employer's rate is determined in

accordance with the following formula:

Subtract the TLL from the TML (TML – TLL), then divide by the TLL; multiply the resulting number by C%; then add 100 to the resulting number, which will equal the EM%.

TML = Actual losses of the employer for the experience period as reduced in accordance with the maximum value. For individually rated employers, the EM% calculation will use the lower of the total modified losses from either the tabular reserve system or the MIRA reserve system. The TML that will be used in the calculation of the group EM% will be the lower of the TMLs from either the tabular reserve system or the MIRA reserve system, as determined at the individual employer level.

TLL = Total Limited Losses = TEL x LLR.

TEL = Total expected losses as determined by applying the National Council of Compensation Insurance (NCCI) expected loss rate to the NCCI classification payroll of each NCCI classification in the employer's experience period, as provided in appendixe A of rule 4123-17-04 of the Administrative Code. The total expected losses are then used to determine the maximum value of a loss, credibility and CX constant.

LLR = Limited Loss Ratio = 1 - CX/C%. This ratio is calculated for each credibility group within each industry group and is published as Table 1, Part C, in Rule 4123-17-05 of the Administrative Code for private employers and Rule 4123-17-33 of the Administrative Code for public employer taxing districts.

C% = Credibility given to an employer's own experience. Credibility is assigned by applying the employer's total expected losses to Table 1, Part A, in Rule 4123-17-05 of the Administrative Code for private employers and Rule 4123-17-33 of the Administrative Code for public employer taxing districts.

CX = Constant for each employer size group (Group Maximum Value Pool).

EM% = Credit or penalty applied to basic rate.

D. An employer's expected losses shall be the sum of the expected losses for each of its classifications. The expected losses for a classification shall be obtained by applying the expected loss rate of the table of rates to the employer's four-year payroll of the classification.
E. The "experience period" shall be the oldest four of the latest five calendar years immediately preceding the beginning of the payroll reporting period to which the revised rates are applicable.
F. Experience modification shall be subject to the following conditions and limitations:
   1. Actual losses shall include all incurred costs and shall be limited to the amounts stated in the credibility table according to the total expected losses of an employer.
   2. An employer shall not be eligible for experience modification of basic rates unless its expected losses are at least the minimum amount in the credibility table, as periodically established for the applicable rating period by rule adopted by the Administrator with the advice and consent of the Workers' Compensation Oversight Commission and filed with the Secretary of State and the Legislative Services Commission.
   3. The maximum credit modification will be ninety-five per cent. Commencing with rating years beginning January 1, 1995 and later, there shall be no limitation on the penalty modification.
G. Commencing with the rating year beginning July 1, 1987 and all subsequent rating years, all manual classifications of the State Insurance Fund are subject to experience rating (i.e., merit rating).

4123-17-04 Classification of occupations or industries
eff. 07/01/01

The administrator of workers' compensation, with the advice and consent of the workers' compensation oversight commission, has authority to approve the classification of occupations or industries pursuant to sections 4121.12, 4121.121, and 4123.29 of the Revised Code. The administrator hereby establishes the following classifications of occupations or industries to be effective July 1, 2002, as indicated in the attached appendix A, the classification of occupations or industries that is based upon the National Council on Compensation Insurance as required by division (A)(1) of section 4123.29 of the Revised Code.

4123-17-05 Private employer credibility table used for experience rating
eff. 07/01/02

The administrator of workers' compensation, with the advice and consent of the workers' compensation oversight commission, has authority to approve contributions made to the state insurance fund by employers pursuant to sections 4121.121, 4123.29, and 4123.34 of the Revised Code. The administrator hereby sets the credibility table parts A, B, and C to be effective July 1, 2002, applicable to the payroll reporting period July 1, 2002, through June 30, 2003, for private employers as indicated in the attached appendixes A, B, and C.

4123-17-06 Private employer contributions to the State Insurance Fund
eff. 07/01/02

The administrator of workers' compensation, with the advice and consent of the workers' compensation oversight commission, has authority to approve contributions made to the state insurance fund by employers pursuant to sections 4121.121, 4123.29, and 4123.34 of the Revised Code. The administrator hereby sets the NCCI manual classification base rates, and NCCI manual classification expected loss rates per one hundred dollar unit of payroll to be effective July 1, 2002, applicable to the payroll reporting period July 1, 2002, through June 30, 2003, for private employers as indicated in the attached appendix A.

Effective July 1, 2002, an employer that is not participating in the group rating program will receive a discount of 9.4 percent from its pure premium rate. This discount is applied before the administrative cost, DWRF and additional DWRF assessment. Note that the base rates filed in the attached appendix A have been increased by 7.3 percent to allow for this discount.

4123-17-07 Officers of corporations, partnerships and sole proprietorships, family farm corporations, and ordained ministers
eff. 09/01/93

A. Officers of corporations.
   1. The actual remuneration of an executive officer of a corporation, such as president, vice president, secretary, treasurer, and any other executive officer enumerated in and empowered by the corporate charter or any regularly adopted bylaws of the corporation and elected or appointed and empowered by the directors to perform duties for the corporation, shall be included in the payroll report of the corporation, not to exceed an average weekly maximum as shall be periodically established by the Bureau of Workers' Compensation by way of a rule approved by the Workers' Compensation Advisory Commission and filed with the Secretary of State and the Legislative Service Commission as provided under Section 111.15 of the Revised Code. This information shall also be published in the Ohio Workers' Compensation Insurance Fund Manual. Such remuneration shall be assigned to the classification applicable to the duties performed.
   2. Paragraph (A)(1) of this rule shall not apply to family farm corporations as defined in Division (E) of Section 4123.01 of the Revised Code. The remuneration of the officers of such corporation shall not be reported as part of the payroll of such employer, unless such employer elects to include as an "employee" within Chapter 4123. of the Revised Code, any of the officers of the family farm corporation, in which case the procedure outlined in paragraph (B) of this rule shall be applicable.

B. Partnerships, sole proprietorships, limited partnerships, and family farm corporations.
   1. If the employer is a partnership, sole proprietorship, limited partnership, or family farm corporation, the remuneration of the sole proprietor, member of the partnership, member of a limited partnership, or officer of the family farm corporation shall not be reported as part of the payroll of such employer, unless the sole proprietor, the partnership, the limited partnership or the family farm corporation elects to include any such person as an employee as provided in Division (A)(2) of Section 4123.01 of the Revised Code. In the event of such election, the employer shall serve written notice to the Bureau of Workers' Compensation on the appropriate bureau form, which notice shall name the person or persons to be covered and whose remuneration shall be included in payroll reports for premium purposes. Upon the filing of such election, sole proprietors, members of a partnership, members of a limited partnership, and officers of a family farm corporation who sustain injuries or contract occupational diseases in the course of and arising out of employment shall be entitled to receive compensation and benefits as provided in Chapter 4123. of the Revised Code; provided, however, that the coverage for such persons shall not be effective until such notice has been filed with the Bureau of Workers' Compensation.
   2. Upon the filing of such election as provided in paragraph (B)(1) of this rule, the actual remuneration of a sole proprietor, member of a partnership, member of a limited partnership, or officer of a family farm corporation

shall be reported and included in the payroll report of the employer subject to a weekly minimum and maximum as shall be periodically established by the Bureau of Workers' Compensation by way of a rule approved by the Workers' Compensation Advisory Commission and filed with the Secretary of State and the Legislative Service Commission as provided under Section 111.15 of the Revised Code.[1] This information shall also be published in the "Ohio Workers' Compensation Insurance Fund Manual." Such remuneration shall be assigned to the classification applicable to the duties performed.

3. Upon receipt of the form requesting coverage for the sole proprietor, member of a partnership, members of a limited partnership, or officer of a family farm corporation, the bureau shall refer the form to the Risk Processing Section for processing. Coverage shall remain in effect, and the employer shall be responsible for the payment of premium thereon, until the bureau receives written notice from the sole proprietor, the partnership, the limited partnership, or the family farm corporation requesting termination of coverage, or until terminated by the bureau pursuant to paragraph (B)(4) of this rule.
4. In the case of a sole proprietorship, partnership, limited partnership, or family farm corporation, failure to pay premiums timely shall terminate coverage. In the case of a sole proprietorship, partnership, limited partnership, or family farm corporation which reports payroll for its employees only, the failure to report payroll and to pay premiums thereon for any person for whom coverage is elective shall terminate coverage for any such person only. In the event of termination of coverage for non-payment of premium, a sole proprietor, a partnership, a limited partnership, or a family farm corporation may reinstate elective coverage only upon the filing of a subsequent application form. Reinstatement of coverage shall be effective only upon receipt of the executed form and payment of premium for such elective employees, and no retroactive coverage may be granted except as provided in rule 4123-14-03 of the Administrative Code.

C. Duly ordained, commissioned, or licensed ministers and assistant or associate ministers.

1. Division (A)(2)(a) of Section 4123.01 of the Revised Code excludes from coverage duly ordained, commissioned, or licensed ministers or assistant or associate ministers of a church in the exercise of their ministry. The remuneration for such persons shall not be reported as part of the payroll of a church employer, unless the church elects to include as an employee such persons as provided in Division (A)(2) of Section 4123.01 of the Revised Code. In the event of such election, the employer shall serve written notice to the Bureau of Workers' Compensation. Notice shall name the person or persons to be covered and whose remuneration shall be included in payroll reports for premium purposes. After proper election and notice, such persons shall be considered employees and entitled to compensation and benefits as provided in Chapter 4123. of the Revised Code, provided, however, that the coverage for such persons shall not be effective until such notice has been filed with the Bureau of Workers' Compensation.
2. Upon receipt of written notice or the appropriate form requesting coverage for the minister or ministers, the bureau shall refer such written notice or form to the Risk Processing Section for processing. Coverage shall remain in effect, and the employer shall be responsible for the payment of premium thereon, until the bureau receives written notice from the church employer requesting termination of coverage, or until terminated by the bureau pursuant to paragraph (C)(3) of this rule.
3. In the case of a church employer, failure to pay premiums timely shall terminate coverage for such employer. In the case of a church employer which reports payroll for its employees only, the failure to report payroll and to pay premiums thereon for any minister for whom coverage is elective shall terminate coverage for any such minister only. In the event of termination of coverage for non-payment of premium, a church employer may reinstate elective coverage only upon the filing of a subsequent application form. Reinstatement of coverage shall be effective only upon the receipt of the executed form and payment of premium for such elective employees, and no retroactive coverage may be granted except as provided in rule 4123-14-03 of the Administrative Code.

4123-17-08 Classifications According to National Council on Compensation Insurance
eff. 07/01/00

In accordance with division (A)(1) of section 4123.29 of the Revised Code, the purpose of this rule is for the Bureau of Workers' Compensation to conform the classifications of industries according to the categories the National Council on Compensation Insurance establishes that are applicable to employers in Ohio. This rule is based upon "Rule IV, Classifications," effective July 1, 2000, of the classification rules of the National Council on Compensation Insurance. The rule is used with the permission of the National Council on Compensation Insurance and is modified to conform to the requirements of the Ohio Administrative Code and the Bureau of Workers' Compensation. Where the National Council on Compensation Insurance scopes of basic manual classifications contains additional rules and information relating to the reporting of payroll or classification of industries under the manual classifications, such scopes and rules shall apply under the rules of the Bureau of Workers' Compensation,

[1]Currently, not less than an average of one hundred dollars per week, or two thousand, six hundred dollars semi-annually, nor more than an average of eight hundred dollars per week, or twenty thousand eight hundred dollars semi-annually, or an aggregate of forty-one thousand six hundred dollars annually.

unless otherwise specifically excepted.

A. General explanation

The object of the classification system is to group employers into classifications so that the rate for each classification reflects the exposures common to those employers. Subject to certain exceptions described later in this rule, it is the business of the employer within a state that is classified, not the separate employments, occupations, or operations within the business.

B. Explanation of classifications

1. Basic classifications

All classifications in the manual are basic classifications, other than the standard exception classifications. Basic classifications describe the business of an employer such as:

Business	Classification
Manufacture of a product	Furniture manufacturing
A process	Engraving
Construction or erection	Carpentry
A general type or character of business	Hardware Store
A service	Beauty Parlor

2. Standard exception classifications

Some occupations are common to so many businesses that special classifications have been established for them. They are called standard exception classifications. Employees within the definition of a standard exception classification are not included in a basic classification unless the basic classification specifically includes those employees. The standard exception classifications are defined below:

a. Clerical

i. Clerical office employees, code 8810, not specifically included in descriptions of other classes assigned to the policy, and not included by other special rules, may qualify for inclusion in standard exception code 8810 provided the definition of clerical office duties and the definition of a clerical office are both met.

(a) Clerical office duties. The duties of a clerical office employee include creation or maintenance of financial or other employer records, handling correspondence, computer composition, technical drafting, and telephone duties, including sales by phone. The clerical office classification continues to apply to a qualified clerical office employee who performs a duty outside of a qualified office area when that duty does not involve direct supervision or physical labor and is directly related to that employee's duties in the office. These duties do not exclude the depositing of funds at the bank, purchase of office supplies, and pickup or delivery of mail provided they are incidental and directly related to that employee's duties in the office.

However, for purposes of this rule, the definition of clerical duties excludes outside sales or outside representatives; any work exposed to the operative hazards of the business; and any work, such as a stock or tally clerk, which is necessary, incidental, or related to any operations of the business other than a clerical office.

(b) Clerical office. A clerical office is a work area separated and distinguishable from all other work areas and hazards of the employer by floors, walls, partitions, counters, or other physical barriers.

A clerical office excludes work or service areas, areas where inventory is located, products are displayed for sale, or to which the purchaser customarily brings the product from another area for payment.

ii. Clerical telecommuter employees, code 8871, not specifically included in descriptions of other classes assigned to the policy, and not included by other special rules, may qualify for inclusion in standard exception code 8871 provided the definition of clerical telecommuter duties and the definition of residence office are both met.

(a) Clerical telecommuter duties. The duties of a clerical office employee include creation of maintenance of financial or other employer records, handling correspondence, computer composition, technical drafting, and telephone duties, including sales by phone. The clerical telecommuter classification continues to apply to a qualified clerical telecommuting employee who performs duty outside of a qualified office residence when that duty does not involve direct supervision or physical labor. These duties do not exclude the depositing of funds at the bank, purchase of office supplies, and pickup or delivery of mail provided they are incidental and directly related to that employee's duties in the residence office. However, for purposes of this rule, the definition of clerical telecommuter duties excludes outside sales or outside representative; any work exposed to the operative hazards of the business or related to any operations

of the business other than a residence clerical office.

(b) Residence office. A residence office is a clerical work area located within the dwelling of the clerical employee. For the purposes of this code, the dwelling of the clerical employee must be separate and distinct from the location of the employer.

b. Drafting employees, code 8810, are clerical employees engaged exclusively in drafting and confined to office work as described in paragraph (B)(2)(a)(i) of this rule. The entire payroll of any such employees exposed to any other operations shall be assigned to the highest rated classification of operations to which they are exposed.

Telecommuting drafting employees, code 8871, are clerical telecommuting employees engaged exclusively in drafting and confined to a residence office as described in paragraph (B)(2)(a)(ii) of this rule.

c. Drivers, chauffeurs and their helpers, code 7380, are employees engaged in such duties on or in connection with a vehicle. This classification also includes garage employees and employees using bicycles in their operations.

d. Salespersons, collectors, or messengers, outside, code 8742, are employees engaged in such duties away from the employer's premises. This classification shall not apply to employees who deliver merchandise. Employees who deliver merchandise shall be assigned to the classification applicable in that risk to drivers even though they also collect or sell. If they walk or use public transportation, they shall be assigned to the governing classification.

NOTE: Automobile salespersons, code 8748, are employees engaged in such duties on and away from the employer's premises. Such employees are subject to treatment as salespersons, collectors, or messengers, outside, for purposes of this rule, but are assigned to code 8748.

3. General inclusions

a Some operations appear to be separate businesses, but they are included within the scope of all classifications other than the standard exceptions classifications. These operations are called general inclusions and are:

i. Commissaries and restaurants for the insured's employees. Such operations shall be assigned to a separate classification if conducted in connection with construction, erection, lumbering, or mining operations.

ii. Manufacture of containers such as bags, barrels, bottles, boxes, cans, cartons, or packing cases by the employer for use in the operations insured by the policy.

iii. Hospitals or medical facilities operated by the insured for its employees.

iv. Maintenance or repair of the insured's buildings or equipment by the insured's employees.

v. Printing or lithographing by the insured on its own products.

b. A general inclusion operation shall be separately classified only if:

i. Such operation constitutes a separate and distinct business of the insured as provided in paragraph (D) of this rule, or

ii. It is specifically excluded by the classifications wording, or

iii. The principal business is described by a standard exception classification.

4. General exclusions

Some operations in a business are so unusual for the type of business described by the basic classification applicable to the business that they are separately classified. These operations are called general exclusions and are classified separately unless specifically included in the basic classification wording. General exclusions are:

a. Aircraft operation: all operations of the flying and ground crews.

b. New construction or alterations.

c. Stevedoring, including tallying and checking incidental to stevedoring.

d. Sawmill operations: sawing logs into lumber by equipment such as circular carriage or band carriage saws, including operations incidental to the sawmill.

e. Employer-operated day care service.

5. Governing classification

The governing classification at a specific job or location is the classification, other than a standard exception classification, that produces the greatest amount of payroll. In instances where no basic classification is applicable, the governing classification is the standard exception classification that produces the greatest amount of payroll.

6. Principal business

The principal business is the business reflected by the classification with the greatest amount of payroll,

excluding standard exception and general exclusion operations. If the business is best described by a standard exception operation and no basic classification other than that applicable to general inclusion or general exclusion operations applies, then the standard exception operation that produces the greatest amount of payroll for the business shall be the principal business.

C. Classification wording

1. Captions
   Captions which precede related classifications are a part of the classification wording.
2. Notes
   Notes following a classification are part of that classification and control its use.
   Example:
   Store: Fruit or vegetable, retail. No handling of fresh meats.
   In this example, "store" is the caption and "no handling of fresh meats" is the note. Both are part of the classification wording.
3. Words and phrases
   a. "All employees," "All other employees," "All operations," or "all operations to completion": If a classification includes any of these phrases, no other classification shall be assigned to that risk unless specifically directed by classification wording, even though some operations or employees are at a separate location.
      Examples:
      i. Code 9186, Circus, traveling, all employees. All of the employees of such a risk shall be assigned to this classification.
      ii. Code 8385, bus company, garage employees. Code 7382, bus company, all other employees. All employees, other than garage employees shall be assigned to code 7382 in such a risk.
      iii. Code 5402, greenhouse erection, all operations. All work for erection of a greenhouse shall be assigned to code 5402.
      iv. Code 6005, jetty construction, all operations to completion. All work for the construction of a jetty from beginning to end of the project shall be assigned to code 6005.
      Exceptions:
      v. Operations described by code 8227, construction for erection permanent yard, and code 5606, contractor, executive supervisor or construction superintendent.
      vi. Classification describing an operation which is a standard exception or general exclusion shall apply.
      vii. Any separate and distinct business shall be separately classified when conditions of paragraph (D) of this rule exist.
      The examples of this paragraph of this rule are subject to exceptions of this paragraph of this rule.
   b. "Clerical" means clerical office employees and drafting employees as defined in paragraphs (B)(2)(a) and (b) of this rule.
   c. "Drivers" means drivers, chauffeurs, and their helpers as defined in rule in paragraph (B)(2)(c) of this rule.
   d. "Includes" or "&": If a classification contains "Includes" or "&" the operations or employees which are so designated shall not be assigned to a separate classification even though such operations or employees are described by another classification or are at a separate location.
      Example:
      Code 5183, insulation, steam pipe or boiler & driver, includes shop.
      This classification also applies to shop operations and drivers.
   e. "Local manager" means the employee in direct charge of operative procedure in a yard and as such is normally subject to the hazards of the governing classification. Such an individual may appear in the organization as "manager" or otherwise or without title.
      The payroll of any local managers shall be assigned to the governing classification
   f. "No" or "Not": A classification which includes a restrictive phrase beginning with "No" or "Not" shall not apply to any risk which conducts any operation described in the restrictive phrase.
      Exceptions:
      i. For mercantile businesses, such as dealers or stores, or for mining business, this rule applies to each location.
      ii. For construction operations, this rule applies to each job or location.
      Example:
      iii. Code 8106, steel merchant, not applicable to junk dealers. This classification shall not be assigned to a steel merchant which also deals in junk. This risk shall be assigned to code 8263, junk dealers.
   g. "NOC" means "Not otherwise classified." A classification designated "NOC" shall apply only if no other classification more specifically describes the insured business.

h. "Or": "Or" also means "And."
Example:
Code 2586, cleaning or dyeing.
Cleaning or dyeing also means cleaning and dyeing.

i. "Salespersons" means salespersons, collectors, and messengers as defined in paragraph (B)(2)(d) of this rule.

j. "Story in Height": The basic manual contains several classifications that refer to "Stories in Height." A representative sampling of classifications of this nature includes: code 5037, painting: metal structures, over two stories; code 5059, iron or steel: erection frame structures not over two stories; code 5651, carpentry, dwellings, three stories or less.
For structures, a "story" is defined as being fifteen feet in height.

k. "To be separately rated": If a classification requires operations employees " To be separately rated," all such operations or employees shall be separately classified when the conditions of paragraph (D)(4) of this rule exist.
Example:
Code 4131, Mirror Manufacturing, Manufacturing of Glass, Frames, Backs, or Handles to be separately rated. In a risk which makes mirrors, the work of producing glass, or fabricating frames, backs, or handles shall be separately classified.

D. Assignment of classifications

1. Object of classification procedure
The object of the classification procedure is to assign the one basic classification which best describes the business of the employer subject to certain exceptions described in this rule, each classification includes all the various types of labor found in a business. It is the business which is classified, not the individual employments, occupations or operations within a business. Additional classifications shall be assigned as provided below.

2. Assignment of additional basic classifications
The word "operation" used within this rule also means "activity," "enterprise," "process," "secondary business," or "undertaking" in either the singular or plural form.

a. More than one basic classification may be assigned to an insured who meets the conditions of paragraph (D)(2)(a)(i), (D)(2)(a)(ii), or (D)(2)(a)(iii) of this rule:

i. The insured's principal business is described by a basic classification that requires certain operations or employees to be separately rated. See paragraph (B)(6) of this rule for the definition of "principal business," and paragraph (C)(3)(k) of this rule for definition of "to be separately rated."

ii. The insured conducts one or more of the following operations: construction, or erection; farming; employee leasing; labor contracting; temporary labor services; or mercantile business. See paragraphs (D)(6), (D)(7), (D)(8), and (D)(9) of this rule for conditions under which additional basic classification may be assigned for these operations.

iii. The insured conducts more than one operation in a state.

(a) For purposes of this rule, an insured is conducting more than one operation in a state if portions of the insured's operations in that state are not contemplated by the classification applicable to the insured's principal business. To qualify for a separate classification, the insured's additional operation must:

(i) Be able to exist as a separate business if the insured's principal business in the state ceases to exist.

(ii) Be located in a separate building or on a separate floor in the same building or on the same floor physically separated from the principal business by structural partitions. Employees engaged in the principal business must be protected from the operating hazards of the separate additional operation.

(iii) Maintain proper payroll records. See paragraph (E)(2)(b) of this rule for the description of proper payroll records.

(b) If the separate additional operation is not contemplated by the classification applicable to the insured's principal business and meets all the conditions listed in paragraph (D)(2)(a)(iii)(a) of this rule, the insured is considered to be engaged in an additional operation and a separate basic classification may be assigned to each operation so qualified.

(c) If the additional operation does not meet all conditions listed in paragraph (D)(2)(a)(iii)(a) of this rule and is not contemplated by the classification applicable to the insured's principal business and has a rate that is:

(i) Lower than the insured's principal business, the operation will be assigned to the same classification as the insured's principal business.
(ii) Higher than or equal to the insured's principal business, the operation will be assigned to the classification that describes the additional operation.

b. Policies with more than one classification may include employees working under several classifications. Payroll assignment for such employees is subject to paragraph (E) of this rule.

3. Classifications limited to separate businesses
The assignment of certain classifications is limited by their notes to separate and distinct businesses because they describe an operation that frequently is an integral part of a business described by another classification.
Example:
Code 4511, analytical chemist.
Includes laboratory and outside employees. Shall not be assigned to a risk engaged in operations described by another classification unless the operations subject to code 4511 are conducted as a separate and distinct business.

4. Standard exception and general exclusion operations
Standard exception and general exclusion operations shall be separately classified unless specifically included in a classification assigned to the business. Classifications for standard exception and general exclusion operations apply even if the basic classification includes phrases such as "All employees" or "All operations."

5. Business described by a standard exception classification.
If the principal business is described by a standard exception classification, the operations of all employees not included in the definition of the standard exception classification shall be assigned to the separate basic classification which most closely describes their operation.
Example:
The insured is a bank.

Employees	Assignment
Clerical office	Code 8810, clerical office employee
Maintenance, and night watch guards	Code 9015, buildings, operation by owner or lessee
Cafeteria or restaurant	Code (_____), appropriate restaurant code

6. Construction or erection operations
Each distinct type of construction or erection operation at a job or location shall be assigned to the classification which specifically describes such operation provided separate payroll records are maintained for each operation. For purposes of classification, construction or erection classifications are identified in the NCCI classification of industries, appendix B of rule 4123-17-04 of the Administrative Code, by a designated symbol immediately following the classification code number as indicated in the "explanation of symbols" to such appendix.
Any such operation for which separate payroll records are not maintained shall be assigned to the highest rated classification which applies to the job or location where the operation is performed.
A separate construction or erection classification shall not be assigned to any operation which is within the scope of another classification assigned to such a job or location.

a. Construction or erection classifications: insured subcontractors.
i. A subcontractor who performs a single type of work on a construction project or job shall be classified on the basis of the classification describing the particular type of work involved.
Example:
The insured subcontractor who performs only excavation work in connection with the construction of a sewer would be classified under excavation, code 6217, rather than sewer construction, code 6306.
ii. All operations in conjunction with concrete construction including making and erecting forms, placing reinforcing steel and stripping forms, when done by subcontractors, shall be assigned to the appropriate concrete construction classification.

b. Construction or erection classifications: uninsured subcontractors.
Uninsured subcontractors covered under the principal contractor's policy are classified on the basis of the classifications that would apply if the work were performed by the principal's own employees.
Example:
The uninsured subcontractor who performs only excavation work but is covered under the policy of the principal contractor who is performing the construction of a sewer would be classified under sewer

construction, code 6306.

7. Employee leasing, labor contractors, and temporary labor services.
   Classify workers assigned to clients the same as direct employees of the client entity performing the same or similar duties. If the client has no direct employees performing the same or similar duties, leased employees are classified as if they were direct employees of the client entity.
8. Farm operations
   For the purpose of the application of workers' compensation farm classifications, a farm is defined as any parcel or parcels of land used for the purpose of agriculture, horticulture, aviculture, dairying, or stock or poultry raising, as a business or commercial venture. A division of payroll may be allowed for each separate and distinct type of commercial farm operation as described by farm classifications, provided that separate records of payroll are maintained. In the event that the payroll records do not reveal clearly an accurate segregation of payroll applicable to farm classifications, the entire payroll for the farm must be segregated on the basis of proportionate acreages.
   Each classification includes all employees, other than inside domestic workers, including drivers and all normal repair and maintenance of buildings or equipment performed by the employees of the employer. Such activities as the maintenance of cows, hogs or chickens for family use; a family orchard or truck garden, and hay or grain crop raised for the purpose of maintaining work animals on the farm must be considered usual and incidental to the operation of any type of farm. For purposes of classification, farm classifications are identified in the NCCI classification of industries appendix B of rule 4123-17-04 of the Administrative Code, by a designated symbol immediately following the classification code number as indicated in the "explanation of symbols" to such appendix.
9. Mercantile businesses
   For the purpose of the application of workers' compensation mercantile classifications, a mercantile business is defined as any store or dealer engaged in the sale of goods or merchandise or in the sale of services. For mercantile businesses, the classification is determined separately for each location.
   The assignment of a classification to a store is based upon the principal type of merchandise sold, and whether the operations are wholesale or retail. The following definitions and instructions are to be observed in determining the appropriate store classification:
   (a) Type of merchandise sold: if a store sells several types of merchandise, each of which may be subject to a different classification, such a store shall be assigned on the basis of the principal category of the merchandise sold. The term "principal" means more than fifty per cent of the gross receipts.
   (b) Wholesale versus retail: retail applies to the sale of merchandise to the general public for personal or household consumption or use and not for resale. Wholesale applies to the sale of merchandise for resale to others; or to the sale to manufacturers, builders, contractors, or others for use in their business, or as raw materials. A store that sales merchandise on a combined wholesale and retail basis shall be assigned to the appropriate store classification depending upon whether the gross receipts are principally from wholesale or retail sales. The term "gross receipts" means gross receipts less receipts derived from the sale of lottery tickets. The term "principally" means more than fifty per cent of the gross receipts.
   Exception:
   If it is determined that a store's sales are clearly retail in nature, the appropriate retail store classification may be assigned regardless of the above definition of retail. Examples of this type of situation would be stores selling art work or art supplies in a shopping mall when the majority of sales are to artists who use the materials in their business or art work purchased by businesses. In these cases, the stores would clearly be classified as retail except for the ultimate use or purchaser of the products.
   For purposes of classification, mercantile business classifications are identified in the NCCI classification of industries, appendix B of rule 4123-17-04 of the Administrative Code, by a designated symbol immediately following the classification code number as indicated in the "explanation of symbols" to such appendix.
10. Repair operations
    Risks having shop operations that involve the repair of a product for which there is no repair classification are to be assigned to the classification that applies to the manufacture of the product unless such repair work is specifically referred to by another classification phraseology, footnote, or definition in the manual.
11. Recycling operations.
    The collection, sorting and handling of recycling materials for resale to others, are to be assigned to the appropriate store for dealer classification, or to the classification which most closely describes the business. Risks having operations that involve the reuse of materials for the production of a new product are to be

assigned to the classification that applies to the manufacture of the product unless such work is specifically referred to by another classification phraseology, footnote, or definition in the manual.

E. Payroll assignment: multiple classifications: interchange of labor.

1. Miscellaneous employees.
   Miscellaneous employees are those who perform duties conducted in common for separate operations which are subject to more than one basic classification. The payroll of any miscellaneous employees shall be assigned to the governing classification. Such employees include general superintendents, maintenance or power plant employees elevator operations, shipping or receiving clerks and yard workers.
   Example:
   Four story factory, two floors general job machine shop and two floors plastic goods manufacturing:
   Code 3632, machine shop NOC, applies to machine shop. Code 4452, plastics manufacturing, applies to plastic goods manufacturing. The elevator operators, porters and cleaners serving all four floors shall be assigned to the governing classification.
   Exception:
   If the governing classification is a standard exception classification, refer to paragraph (D)(5) of this rule.
2. Interchange of labor
   Some employees, who are not miscellaneous employees, may perform duties directly related to more than one classification properly assignable to any employer's policy. In such circumstances, an employee's remuneration may be divided between two or more such classifications provided that:
   a. The classifications may be properly assigned to the employer according to the rules of the classification system, and,
   b. The employer maintains proper payroll records which disclose the actual payroll by classification for each such individual employee. Such records must reflect the actual time spent working within each job classification and an average hourly wage comparable to the wage rates for such employees within the employer's industry. An estimated or percentile allocation of payroll is not permitted. If original payroll records do not disclose the actual payroll applicable to each classification, the entire payroll of the individual employee shall be assigned to the highest rated classification that represents any part of his or her work.
   c. If an employee qualifies for division of payroll between two or more basic classification codes and also engages in operations contemplated by codes 8810, 8742, 8748, or 8871, the payroll for such standard exception operations will be allocated to the basic classification code with the largest amount of payroll applicable to that employee. If the distribution of payroll for the employee is such that no single basic classification code represents the largest amount of that employee's payroll, then the payroll for the operations contemplated by codes 8810, 8742, 8748, or 8871 will be assigned to the highest rated classification code representing any part of that employee's work.
   d. When a division of payroll exists for an individual employee, payroll for holiday, vacation, sick pay, overtime and all forms of remuneration not directly attributable to a specific classification code shall be allocated to the classification code with the greatest amount of payroll applicable to the individual employee. If no one classification code applicable to the employee has the greatest amount of payroll, the payroll for holiday, vacation, sick pay, overtime and all other forms of remuneration not directly attributable to a specific classification code shall be allocated to the highest rated classification code applicable to the employee.
      Exceptions: Code 8810, clerical office employees, code 8871, clerical telecommuter employees, code 8742, salespersons, collectors, or messengers, outside, and code 8748, automobile salespersons, are not available for division of payroll under this rule. However, when an interchange of labor exists between code 8810 and code 8871, code 8871 will be assigned when the employee spends more than fifty percent of the time worked telecommuting as described by paragraph (B)(2)(a)(ii) of this rule and code 8810 will be assigned when the employee spends fifty percent or less of the time worked telecommuting as described by paragraph (B)(2)(a)(i) of this rule.
      Examples: The following examples have been developed to indicate how the foregoing rule shall be applied in specific circumstances and to illustrate the rules proper application in accordance with its basic intent.
      i. In a business that manufactures clocks, all employees must be assigned to either clock manufacturing, code 3385, clerical, code 8810, sales, outside, code 8742, or drivers, code 7380. In this example, division of payroll would only be allowable for employees whose work is divided between activities eligible for assignment to clock manufacturing, code 3385, and drivers code 7380.
      ii. In a business best described by store: furniture and drivers, code 8044, all employees must be assigned to either that code or clerical, code 8810, or sales, outside, code 8742. Since in this

example, drivers are included in the basic classification and division of payroll with clerical, code 8810, or sales, outside, code 8742 is not allowed, no division of payroll would be permitted.

iii. Some classifications require that certain operations or employees be classified separately. Code 4279, wallpaper manufacturing, directs the assignment of code 4239 to the actual manufacturing of the raw paper stock. For a business that manufactures paper, and further processes this paper into wallpaper, codes 4279 and 4239 would be applied to the policy. Payroll of employees who interchange duties between these two operations may be divided in accordance with the provisions of paragraph (E) of this rule.

4123-17-09 Clerical office payroll
eff. 07/01/93

Clerical office payroll shall include only the payroll of those employees whose duties are confined to keeping the books and records of the risk, conducting correspondence, and drafting, or who are engaged wholly in office work where such books and records are kept, having no other duties of any nature in or about the risk's premises.

4123-17-10 Excess premiums
eff. 05/01/00

The administrator of workers' compensation, with the advice and consent of the workers' compensation oversight commission, has authority to approve contributions made to the state insurance fund by employers pursuant to sections 4121.121, 4123.29, 4123.32, and 4123.34 of the Revised Code. Pursuant to sections 4123.29 and 4123.34 of the Revised Code, the administrator is required to keep premiums at the lowest level consistent with the maintenance of a solvent state insurance fund and of a reasonable surplus. Pursuant to section 4123.32 of the Revised Code, in the event there is developed as of any given rate revision date a surplus of earned premium over all losses which, in the judgment of the administrator, is larger than is necessary adequately to safeguard the solvency of the fund, the administrator may return such excess surplus to the subscriber to the fund in either the form of cash refunds or a reduction of future premiums. The administrator, with the advice and consent of the workers' compensation oversight commission, shall have the discretion and authority to determine whether there is an excess surplus of premium; whether to return the excess surplus to employers; the nature of the cash refunds or reduction of future premiums; the employers who are subscribers to the state insurance fund who are eligible for the cash refunds or reduction of future premiums; the applicable date of the cash refunds or reduction of future premiums; and any other issues involving cash refunds or reduction of future premiums due to an excess surplus of earned premium.

4123-17-11 Rule of merit rating controlling the employee having but one eye, one hand, etc.
eff. 07/01/93

Should any employee having but one hand, arm, eye, foot or leg thereafter lose any one of the foregoing members in an industrial accident or as the result of an occupational disease, the same shall be merit-rated, not as a permanent total disability, but as a permanent partial disability, based upon the loss of the last member only. The remaining cost shall not be charged against the accident experience of the employer.

4123-17-12 Catastrophe claims
eff. 07/01/90

A. A "catastrophe" is defined as an occurrence in which two or more employees of one employer are killed or receive injuries resulting in permanent and total disability.
B. "Catastrophe cost" is defined as the total medical, compensation, and other costs, including reserves for future compensation costs, as a direct result of a catastrophe.
C. Catastrophe cost in excess of two hundred fifty thousand dollars shall not be included in the experience of a classification or of an employer.
D. Catastrophe cost in excess of the catastrophe value from Part A of the Merit-Rated Credibility Table in effect for the retrospective policy year shall not be included in the annual evaluation or final settlement of that retrospective policy year.
E. Notwithstanding the provisions of this rule, the Administrator may consider any special circumstances which may affect the determination of a catastrophe loss.

4123-17-13 Rule controlling the making of the initial application for rating
eff. 09/01/93

A. The amount of premium due from individual employers is ascertained by applying the basic rate for the occupation or employment in which the employer is engaged to the estimated expenditure of wages for the ensuing six months and also for an additional adjustment period of two months; that is, the advance estimate should be made for a period of eight months. Employers are required to file with the Bureau of Workers' Compensation an application setting forth the name and address of the employer, the location of all places where employees are employed, a description of the work done or industry conducted at each such place, the estimated average number of employees in each kind of work, the estimated total payroll for the ensuing six months, and an estimated total payroll for an additional adjustment period of two months, and such other information as may be requested by the bureau. Upon receipt of the application, the applicant-employer's status will be classified as to the type of industry or nature of the enterprise with respect to the degree of hazard involved and the applicant shall be advised as to his classification, rate and amount of first premium security deposit, calculated on a basis of an estimated expenditure of wages for eight months in advance, and at the same time the applicant will be furnished with an invoice on which to remit payment of such premium security deposit. This premium security deposit shall be retained as an adequate eight-month premium deposit subject to a periodic review by the bureau and any unearned portion of this deposit shall be returned to the employer upon cancellation of the coverage subject to audit.
B. New coverage shall be granted upon receipt of a written binder when deemed to be in the best interest of the risk and the Bureau of Workers' Compensation. Such binder shall be granted by the Administrator or his designee. The binder shall be effective for the period of thirty days from the date of issuance and cannot be renewed. The premium security deposit must be billed by the bureau and paid by the risk before the thirty days expire. Payroll reports and premium charges shall coincide with the effective date of said binder.

4123-17-14 Rule controlling the completion of payroll reports
eff. 07/24/95

A. On July first and January first of each year, after the receipt by the Bureau of Workers' Compensation of the first premium payment, the bureau will furnish private fund employers with proper forms showing premium rates on which to report the actual wage expenditure or payroll in the conduct of the employer's operations for the preceding six -months' period or portion thereof. Such report shall be completed and the premium calculated on the report, and the report and remittance for the amount of the premium shall be returned to the bureau within one month from the date on which the six-month period last past expired.
B. For all counties and public employer taxing districts, by January first of each year, the bureau will furnish the county auditor of each county and the chief fiscal officer of each public employer taxing district in each county with proper forms showing premium rates on which to report the actual wage expenditure or payroll expended in the conduct of the employer's operations for the preceding twelve calendar months. Such report shall be completed and the premium calculated on the report, and each such employer shall return the report and remit the amount of premium due to the bureau as follows:
   1. On or before May fifteenth of each year, no less than forty-five per cent of the premium due.
   2. On or before September first of each year, no less than the total premium due.
C. The terms "payroll" and "wage expenditures" as used in the rules of this chapter of the Administrative Code shall include the entire remuneration allowed by an employer to employees in the employer's service for the applicable period. "Remuneration" shall have the same meaning as defined in Division (H) of Section 4141.01 of the Revised Code as provided by the statutes of the Ohio Bureau of Employment Services, in order that the payroll reporting requirements of the Bureau of Workers' Compensation shall be coordinated with the remuneration reporting requirements of the Ohio Bureau of Employment Services, except as otherwise modified by the rules of this chapter. The definition of remuneration shall apply to all amenable employers who are required or elect to obtain Ohio Workers' Compensation coverage and who pay premiums based upon payroll under Chapter 4123. of the Revised Code, and shall apply to all persons of such employers considered to be employees under the statutes or rules of the Bureau of Workers' Compensation, regardless of whether the employer is required to report payroll or remuneration to the Ohio Bureau of Employment Services under Chapter 4141. of the Revised Code or whether the employer reports payroll or remuneration to the Ohio Bureau of Employment Services for such persons considered to be employees by the Bureau of Workers' Compensation.
D. In determining the reportable payroll or remuneration after July 1, 1995, for all employees who customarily receive tips or gratuities, the employer shall report all actual wages paid and shall include all tips to the extent

they are reportable as remuneration as defined in Paragraph C of this rule.

4123-17-14.1 Misrepresentation of payroll
eff. 10/14/02

A. No employer shall knowingly misrepresent to the bureau of workers' compensation the amount of classification of payroll upon which the premium under this chapter is based. No self-insuring employer shall knowingly misrepresent to the bureau the amount of paid compensation paid by such employer.
B. As used in the rule "knowingly" means that the employer had actual knowledge of the misrepresentation and was aware of that the misrepresentation would cause a certain result. An employer will not be deemed to have knowingly misrepresented its payroll, its classification of payroll, or its paid compensation where the employer's determination of how to report was:
   1. Based on the employer's reasonable interpretation of a law, rule, or manual classification.
   2. Based on prior reporting instructions or written advice received from the bureau.
C. Whenever the bureau of workers' compensation finds that an employer violated division (A) of section 4123.25 of the Revised Code by knowingly misrepresenting its payroll or classification of payroll to the bureau, the administrator or the administrator's designee may impose a penalty upon the employer as follows:
   1. For the first offense, five-hundred dollars or twenty-five percent of the amount of the difference between the premium the employer paid the amount the employer should have paid, whichever is higher.
   2. For a second offense, up to ten times the amount of the difference of the amount of the difference between the premium the employer paid and the amount the employer should have paid.
D. Whenever the self-insuring employers evaluation board finds that a self-insuring employer violated division (B) of section 4123.25 of the Revised code by knowingly misrepresenting its paid compensation to the bureau, the self-insuring employers evaluation board may impose a penalty upon the employer as provided under section 4123.25 of the Revised Code.
E. Except for a self-insuring employer, an employer may appeal a penalty imposed under this rule to the adjudicating committee under section 4123.291 of the Revised Code.

4123-17-15 Staff leasing/professional employer arrangements
eff. 07/01/97

A. As used in this rule:
   1. "Staff leasing/professional employer organization" means a person or employer which arranges with one or more client employers, under written contract, to employ all or part of the work force for a client employer and to place those assigned workers on a permanent basis to the client employer.
      A staff leasing/professional employer organization must meet the following criteria:
      a. Notify all assigned workers that they are employed by the staff leasing/professional employer organization;
      b. Assume responsibility for payment of wages and related taxes for assigned workers from their own account(s) not contingent on receipt of payment from client;
      c. Be responsible for maintaining both adequate and required employment-related records for employees, and for reporting such information as may be required by appropriate governmental agencies;
      d. Comply with applicable state laws regarding workers' compensation insurance coverage.
      Staff leasing/professional employer organization does not include a temporary service agency.
   2. "Temporary service agency" means an employer which is in the business of employing individuals for the purpose of utilizing the services of the individuals for a temporary period of time. For example, a person or client employer may utilize individuals from a temporary services agency for positions vacant due to absences, for temporary skill shortages, or for seasonal workloads.
   3. "Client employer" means a person or employer who obtains all or part of its work force from a professional employer arrangement. Client employer does not mean an employer who is a noncomplying employer as defined in Rule 4123-14-01 of the Administrative Code, noncomplying employers within the meaning of the law.
   4. "Person" includes an individual, firm, association, corporation, partnership, limited liability corporation, or other legal entity.
   5. "Employer" means an employer under divisions (B)(1) and (B)(2) of section 4123.01 of the Revised Code. The employer is an amenable employer for workers' compensation purposes where the assigned workers are counted as the employees of the employer for the purposes of section 4123.01 of the Revised Code.
   6. "Assigned worker" means a person performing service for a client employer under a staff leasing/ professional employer arrangement.

7. "Staff leasing/professional employer arrangement" means an arrangement, under written contract, whereby:
   a. A staff leasing/professional employer organization assigns workers to perform services to a client employer;
   b. The arrangement is intended to be or is, ongoing rather than temporary in nature.

B. Where a client employer enters into a staff leasing/professional employer arrangement, the staff leasing/professional employer organization shall be considered the succeeding employer, solely for purpose of workers' compensation experience, and shall be subject to rule 4123-17-02 of the Administrative Code, basic or manual rate.

If the contractual agreement between a staff leasing/professional employer organization and a client employer is terminated, the portion of the experience of the staff leasing/professional employer organizations related to the client employer shall be transferred to the client employer.

C. A staff leasing/professional employer organization shall notify the bureau of workers compensation of the client employer's name, bureau of workers' compensation risk number, and federal tax identification number within thirty calendar days of entering into a staff leasing/professional employer arrangement with a client employer.

D. A staff leasing/professional employer organization shall maintain complete records, separately listing the payroll of its client employers. Claims will be separately identified according to the client employer.

E. A staff leasing/professional employer organization which enters into a staff leasing/professional employer arrangement with a noncomplying employer or a staff leasing/professional employer organization which fails to comply with this rule shall not be considered the employer for workers' compensation purposes. In these instances the payroll of the assigned workers shall be reported by the client employer under its workers' compensation risk number for workers' compensation premium and claims purposes, unless prohibited by federal law. Claims that are filed by the client employer's assigned workers shall be charged to the experience of the client employer.

4123-17-16 Premium security deposit

eff. 09/01/93

A. Each employer, on the occasion of instituting coverage under Chapter 4123. of the Revised Code, shall submit a premium security deposit.

B. A premium security deposit shall be in an amount equal to thirty per cent of the employer's semiannual premium obligation based on the employer's estimated expenditure for wages for a six-month period, plus thirty per cent of the employer's premium obligation for an additional two-month adjustment period, but in no event shall the premium security deposit collected from an employer be less than ten dollars or more than one thousand dollars.

C. The Bureau of Workers' Compensation shall review the security deposit of every employer who has submitted a deposit of less than one thousand dollars. If, in the opinion of the bureau, the amount of any such employer's deposit is less than the amount due under the law, the bureau may require the employer to submit such additional amount as it shall deem necessary, up to the maximum of one thousand dollars.

D. The premium security deposit collected from an employer shall entitle the employer to the benefits of Chapter 4123. of the Revised Code for the remainder of the six-month payroll reporting period during which such deposit is collected, and for an additional adjustment period of two months from the close of such six-month period. Thereafter, if the employer pays the premium due at the close of any six -month period, coverage shall be extended for an additional eight-month period, beginning from the end of the six-month period for which the employer pays the premium due.

4123-17-17 Auditing and adjustment of payroll reports

eff. 12/11/92

A. Every employer amenable to the workers' compensation law shall keep, preserve and maintain complete records showing in detail all expenditures for payroll and the division of such expenditures in the various divisions and classifications of the employer's business. Such records shall be preserved for at least five years after the respective time of the transaction upon which such records are based.

B. All books, records, papers, and documents reflecting upon the amount and the classifications of the payroll expenditures of an employer shall be kept available for inspection at any time by the Bureau of Workers' Compensation or any of its assistants, agents, representatives or employees. If any private fund, county, or public employer or taxing district fails to keep, preserve and maintain such records and other information reflecting upon payroll expenditures, or fails to make such records and information available for inspection, or fails to furnish the bureau or any of its assistants, agents, representatives or employees, full and complete information in reference to expenditures for payroll when such information is requested, the bureau may

determine upon such information as is available to it the amount of premium due from the employer and its findings shall constitute prima facie evidence of the amount of premium due from the employer.

C. The bureau shall have the right at all times by its members, deputies, referees, traveling auditors, inspectors or assistants to inspect, examine and/or audit any or all books, records, papers, documents and payroll of private fund, county, or public employer taxing district for the purpose of verifying the correctness of reports made by employers of wage expenditures as required by law and rule 4123-17-14 hereof. The bureau shall also have the right to make adjustments as to classifications, allocation of wage expenditures to classifications, amount of wage expenditures, premium rates or amount of premium. No adjustments, however, shall be made in an employer's account which result in reducing any amount of premium below the amount of contributions made by the employer to the fund for the periods involved, except in reference to adjustments for the semiannual and/or adjustment periods ending within twenty-four months immediately prior to the beginning of the current payroll reporting period, when such errors affecting the reports and the premium are brought to the attention of the bureau by an employer through written application for adjustment or found by the bureau.

D. Experience will not be recalculated unless there is an adjustment of an employer's account due to a reclassification of operations. In such event the experience will be recalculated for the same period as the adjustment of the employer's account.

E. Where the bureau has assigned two or more classifications for an employer's operations, the employer shall keep an appropriate record showing a correct and verifiable segregation of all payroll into such classifications. The employer shall prorate all indirect labor payroll and report same under the operating classifications (Manual 8810, Clerical Office, and Manual 8747, Traveling Salesmen, are not operating classifications) assigned. If it is found that the employer has failed to keep such record, that part of the payroll which cannot be reasonably determined by the bureau as belonging to any other classification shall be placed by the bureau under the assigned classification having the highest rate, and the employer will be assessed premium accordingly. To such payroll as is expended after the employer has been notified of these requirements and which is not segregated as herein provided, the highest rate of the employer's assigned classifications shall be applied.

4123-17-18 Employer premium discount rate

eff. 11/19/93

A. Any private fund employer that is in compliance with Section 4123.35 of the Revised Code, except those that are self-insuring, may be eligible for a discount on premium rates. The premium discount rate shall be determined by the Bureau of Workers' Compensation and shall apply only to the prospective premium rate of the qualified employer.
   1. In order to qualify for a premium discount rate, the eligible employer must meet the following criteria:
      a. The employer must not have incurred a compensable injury for one calendar year or more; and
      b. The employer shall maintain an employee safety committee or similar organization or make periodic inspections of the work place. If a discount is granted and a claim for a compensable injury or disease subsequently is filed for the calendar year on which the discount is based, the employer's premium rate shall be increased by the amount of the discounted premium rate.
   2. For the purpose of this rule, "compensable injury" includes all claims whether for injury, occupational disease, or death, in which payment has been made for either compensation or medical benefits pursuant to Sections 4123.56 to 4123.59 or Section 4123.66 of the Revised Code.
   3. The Bureau of Workers' Compensation, with the cooperation of the Division of Safety and Hygiene, may investigate employers for compliance with the criteria of this rule. To assist in this matter, the Division of Safety and Hygiene shall maintain a list of employers that have established employee safety committees or similar organizations or make periodic safety inspections of the work place.

B. Any county or public employer taxing district employer may be eligible for a discount on premium rates.
   1. In order to qualify for a premium discount, the county or public employer taxing district employer must pay its total proper contribution for premiums due to the bureau on or before May fifteenth of each year.
   2. The discount rate will be based upon the three month treasury bill rate as of the auction immediately after December first of the previous year, applied at an annualized rate to the portion of premium paid in advance.
   3. The administrator may provide the discount through a refund or an offset against future contributions due.

4123-17-18.1 Early Payment Discount Program

eff. 4/10/01

A. The administrator of workers' compensation, with the advice and consent of the workers' compensation oversight commission, has authority to approve contributions made to the state insurance fund by employers pursuant to sections 4121.121, 4123.29, and 4123.34 of the Revised Code. Pursuant to section 4123.29 of the Revised

Code, the administrator, with the advice and consent of the oversight commission, may grant a discount as the administrator determines to an employer that makes its semiannual premium payment at least one month prior to the last day on which the payment may be made without penalty.

B. Employer eligibility for early payment discount.
   1. The early payment discount shall be available to any private state fund employer with active coverage. An employer reporting zero payroll is not eligible for the discount.
   2. The employer may participate in any other alternative rating program offered by the bureau.
   3. The early payment discount is available only for an employer that reports its payroll and pays its premiums over the internet through electronic submission on the bureau's website.

C. Operation of the early payment discount.
   1. An employer participating in the early payment discount program may submit to the bureau the employer's payroll, actual or estimated, with payment, at any time during the current reporting period. The actual discount will depend upon the time of payment as provided in paragraph (D) of this rule.
   2. For the early payment discount, the bureau will accept the employer's payment without the employer's payroll, but will not accept the employer's payroll without the employer's premium payment.
   3. The employer shall report the complete payroll for the payroll reporting period by the normal due date for the premium payment. The employer's coverage will lapse if the employer does not file and pay the full amount due as required by the completed payroll report for the reporting period.
      a. The bureau will not refund an overpayment of early premium payments made by the employer until the employer filed the completed payroll report for the reporting period.
      b. Standard penalties will apply to any net balance due from the employer, i.e., total premium due less discounts, dividends, and early payments made.

D. Premium discount for the early payment discount.
   1. The bureau will determine the discount rate for each calendar year based on the prior year's actuarial audit's discount rate. The amount of the discount for early payment will be incremental and will decline based upon the date the employer makes the payment to the bureau.
   2. An employer is eligible for the appropriate early payment discount if the employer reports the payroll and pays the complete premium for the payroll reporting period by the first month of the two month grace period for payment; that is, by the end of January for payments due by the end of February, or by the end of July for payments due by the end of August.
   3. The early payment discount shall apply to the total blended premium paid by the employer after all other discounts, dividends, etc.
   4. For an employer participating in retrospective rating, the early payment discount shall be applied only to the minimum premium as defined in rule 4123-17-44 of the Administrative Code.

4123-17-19 Employer contribution to the Marine Industry Fund
eff. 07/01/97

The administrator of workers' compensation with the advice and consent of the workers' compensation oversight commission, has authority to establish contributions made to the Marine Industry Fund by employers pursuant to Sections 4121.121 and 4131.14 of the Revised Code. The administrator hereby sets the premium rates per one hundred dollar unit of payroll to be effective July 1, 1997 as indicated in attached Appendix A. (See page 96)

4123-17-20 Employer contribution to the Coal-Workers Pneumoconiosis Fund
eff. 07/01/01

The administrator of workers' compensation, with the advice and consent of the workers' compensation oversight commission, has authority to establish contributions made to the coal-workers pneumoconiosis fund by employers pursuant to sections 4121.121 and 4131.04 of the Revised Code. The administrator hereby sets the premium rates per one hundred dollar unit of payroll to be effective July 1, 2001, as indicated in attached appendix A.

Appendix A

Manual	Rate
1112	$3.70
1115	$1.07
1116	$0.83

Note: the above premium rates shall only apply to employers who newly subscribe to the coal-workers pneumoconiosis fund on or after May 15, 1999. The bureau shall institute a moratorium on premium collections from all employers who were subscribers to the coal-workers pneumoconiosis fund prior to May 15, 1999, and who remain subscribers to the fund.

4123-17-22 Traveling expense
eff. 07/01/93

Where traveling salesmen or other employees who travel in the course of their employment, are required to pay their traveling expenses out of their remuneration, the employer, in submitting payroll reports of the earnings of such employees, may deduct from the remuneration an amount representing actual traveling expenses, not exceeding, however, an amount equal to one-third of the remuneration, provided said employer maintains complete detailed records disclosing said expenditures.

4123-17-23 Duties outside the state
eff. 07/01/93

A. The entire remuneration of employees, whose contracts of hire have been consummated within the borders of Ohio, whose employment involves activities both within and without the borders of Ohio, and where the supervising office of the employer is located in Ohio, shall be included in the payroll report.
B. The remuneration of employees of other than Ohio employers, who have entered into a contract of employment outside of Ohio to perform transitory services in interstate commerce only, both within and outside of the boundaries of Ohio, shall not be included in the payroll report.
C. The Bureau of Workers' Compensation respects the extra-territorial right of the workers' compensation insurance coverage of an out of state employer for his regular employees, whose contracts of hire have been consummated in some state other than Ohio, while performing work in the state of Ohio for a temporary period not to exceed ninety (90) days. Employees whose contracts of hire are consummated at a job site in Ohio or employees who have been hired to work specifically in Ohio must be protected for workers' compensation insurance under the Ohio fund.
D. Where there is possibility of conflict with respect to the application of the workers' compensation law because the contract of employment is entered into and all or some portion of the work is or is to be performed in different states, the employer and his employees may mutually agree to be bound by the workers' compensation law of the State of Ohio by executing Form C-110, or mutually agree to be bound by the workers' compensation law of some other state by executing Form C-112, such forms to be obtained from and filed with the Bureau of Workers' Compensation within ten days after execution.

4123-17-25 Military and naval service
eff. 07/01/93

The moneys given by employers to employees while engaged in active military or naval service of the United States of America shall be excluded from the payroll reports which said employers are required to submit to the Bureau of Workers' Compensation for premium purposes unless said employees are also required to render services to said employers while thus engaged in active military or naval service.

4123-17-26 Minimum annual administrative charge
eff. 07/01/97

The administrator of workers' compensation, with the advice and consent of the workers' compensation oversight commission, has authority to calculate contributions to the administrative cost fund by employers pursuant to Sections 4121.121, 4123.341, and 4123.342 of the Revised Code. The administrator hereby establishes that in cases where an employer reports no payroll or calculates total premium due of less than ten dollars for a payroll reporting period the employer shall pay a minimum annual administrative charge at a rate of ten dollars each six months or twenty dollars annually.

4123-17-27 Protest of an employer's experience
eff. 12/14/92

A protest of an employer's experience can be submitted only in writing. Only the employer or a representative with a permanent authorization from that employer can file a protest letter . Such letter must be signed in handwriting. A written, signed protest shall be considered on its merits only if timely received by the Bureau of Workers' Compensation. A written protest is timely filed if the date of receipt stamped on that protest by the bureau is within two years of the initial effective date of the basic rate(s) on which the protested experience is predicated.

4123-17-28 Correction of inaccuracies affecting employers' premium rates
eff. 11/19/93

A. Whenever the Bureau of Workers' Compensation detects an inaccuracy in the recording or processing of data, records, payroll, claims or other pertinent items affecting the risk's status, merit-rated modification or premium, such discrepancy shall be corrected. This correction shall be accomplished regardless of whether this entails increasing or decreasing the risk's merit-rated modification or premium rate. The risk or its representative will be advised of any correction and the effect thereof made under the authority of this rule.
B. Any correction made pursuant to the provisions of paragraph (A) of this rule shall be applied to the current rating year, the immediately preceding rating year, and to all subsequent rating years as of the date on which the error was discovered by the bureau or reported to the bureau, whichever date is earlier, except in matters involving handicap reimbursement and service-connected disabilities and cases covered by rules 4123-17-02, 4123-17-17 and 4123-19-03 of the Administrative Code. In cases where two or more employers may be affected by such correction, the same period of adjustment will be applied to all affected employers.

4123-17-29 Disabled Workers' Relief Fund; employers' assessments and self-insurers' payments
eff. 07/01/94

A. State fund employers.
   1. In order to make Disabled Workers' Relief Fund (DWRF) payments to claimants having dates of injury or disability prior to January 1, 1987, assessments shall be levied in the following manner for so long as payments to such claimants are required:
      a. Private State Fund employers: ten cents per one-hundred-dollar unit of payroll, effective January 1, 1980;
      b. Public employer taxing districts: ten cents per one-hundred-dollar unit of payroll, effective January 1, 1980;
      c. Public employer state agency: ten cents per one-hundred-dollar unit of payroll, effective July 1, 1980.

      These assessments shall be billed at the same time State Insurance Fund premiums are billed and payments shall be credited to the Disabled Workers' Relief Fund.
   2. In order to make DWRF payments to claimants having dates of injury on or after January 1, 1987, assessments shall be levied in the following manner for so long as payments to such claimants are required:
      a. Private state fund employers: one-tenth of one per cent of premium, computed at basic rate, effective July 1, 1993;
      b. Public employer taxing districts: one-tenth of one per cent of premium, computed at basic rate, effective January 1, 1993;
      c. Public employer state agency: one-tenth of one per cent of premium, computed at basic rate, effective July 1, 1993;

      These assessments shall be billed at the same time State Insurance Fund premiums are billed and payments shall be credited to the Disabled Workers' Relief Fund.
B. Self-Insuring employers.
   1. Each Self-Insuring employer shall reimburse the bureau for DWRF payments made in claims in which it is the employer of record, without regard to the date the employer was granted the privilege to pay compensation directly, for all DWRF payments made on or after August 22, 1986. Upon default and a finding of noncompliance by the administrator of workers' compensation, reimbursement shall be made from the Self-Insuring Employers' Guaranty Fund.
   2. Self-Insuring employers shall be billed on a semi-annual basis for the DWRF payments made pursuant to this rule.

4123-17-30 Payroll limitations for corporate officers, sole proprietors, members of partnerships, and family farm corporations
eff. 07/01/94

The Workers' Compensation Board, exercising its authority to establish the total payroll reportable by employers pursuant to sections 4121.12 and 4123.29 of the Revised Code, hereby sets the total payroll limitations for executive officers of corporations, sole proprietors, members of partnerships, and officers of family farm corporations as provided in this rule.

A. For executive officers of corporations, the payroll reportable shall not exceed an average of eight hundred dollars ($800.00) per week, or twenty thousand, eight hundred dollars ($20,800.00) semiannually, or an aggregate of forty-one thousand, six hundred dollars ($41,600.00) annually.
B. For sole proprietors, members of partnerships, and officers of family farm corporations who elect to include themselves as employers under the workers' compensation act and comply with rule 4123-17-07 of the Administrative Code, the payroll reportable shall be not less than an average of one hundred dollars ($100.00) per week or two thousand, six hundred dollars ($2,600.00) semiannually, nor more than an average of eight hundred dollars ($800.00) per week, or twenty thousand eight hundred dollars ($20,800.00) semiannually, or an aggregate of forty-one thousand, six hundred dollars ($41,600.00) annually.
C. This rule shall be effective for all payroll reportable after July 1, 1994.

4123-17-31 Occupational Safety Loan Program
eff. 10/11/94

A. The Bureau of Workers' Compensation shall establish the Occupational Safety Loan Fund. The fund shall consist of penalties collected by the bureau pursuant to Section 4121.47 of the Revised Code and such funds the workers' compensation board transfers from the Safety and Hygiene fund pursuant to section 4121.37 of the Revised Code. Such fund may be commingled with the State Insurance Fund for investment purposes, but the bureau shall maintain a separate accounting of said fund, and all investment earnings of the fund shall be credited to the fund.
B. The Bureau of Workers' Compensation shall be responsible for collecting penalties from employers in accordance with orders issued by a staff hearing officer pursuant to Section 4121.47 of the Revised Code. The employer shall pay the penalty within thirty days of the date of receipt of the staff hearing officer's order imposing such penalty. In the event the employer files an appeal from the order to the court of common pleas, the employer shall pay such penalty within thirty days of the entry of a final order by such court denying the employer's appeal, notwithstanding further appeal.
C. The administrator of workers' compensation shall use the occupational safety loan program to make loans to employers for the purpose of allowing the employer to improve, install, or erect equipment that reduces hazards in the employer's workplace and that promotes the health and safety of employees or to purchase individual safety equipment for employees.
D. The administrator shall lend the moneys of the occupational safety loan fund at a fixed interest rate of two points below the prime rate on the day the loan application is received. This rate shall remain in effect for the term of the loan.
E. The term of a loan shall be based on the useful life of the equipment to be purchased.
F. Only individual safety equipment for employees or equipment that reduces hazards in the employer's workplace and that promotes the health and safety of employees shall be eligible for purchase with moneys from the occupational safety loan fund. Ineligible equipment shall include but shall not be limited to: posters, awards, incentives, surveillance or training materials, research and development equipment, and testing equipment.
G. Loan Limitations
    1. The maximum loan to any employer shall be fifty thousand dollars per fiscal year.
    2. The minimum loan to any employer shall be five thousand dollars per fiscal year.
    3. Loans shall cover no more than ninety per cent of the purchase price of eligible equipment, as assessed at fair market value.
    4. Loans shall not be made for the rental of equipment.
    5. Loan proceeds shall be forwarded directly to the vendor(s) of the equipment to be purchased.
H. Employer requirements and restrictions
    1. Only employers who are in compliance with section 4123.35 of the Revised Code shall be eligible for loans from the occupational safety loan fund.
    2. The employer shall apply for a loan on the forms provided by the bureau.

3. On the application, the employer shall:
   a. Demonstrate that a safety or health problem exists in the workplace;
   b. Specify the safety equipment that is to be purchased, improved, installed, or erected;
   c. Give the individual cost of such acquisitions or alterations;
   d. Describe the manner in which such acquisitions or alterations will reduce hazards in the employer's workplace and promote the health and safety of employees;
   e. Demonstrate through personal and business financial statements, credit reports, estimates, invoices, and tax returns the ability to repay the loan.
4. The employer shall pay a non-refundable, uniform, administrative fee, not to exceed five hundred dollars, to defray costs associated with the loan review and approval process.
5. The employer shall permit the bureau access to the employer's workplace to verify the statements in the loan application. The bureau may use the technical assistance of the Division of Safety and Hygiene to investigate the loan application.
6. The employer shall use loan proceeds solely for the purpose approved in the loan application.
7. The employer may be required to pledge security for the loan, or liens may be filed on the acquisitions as collateral.
8. The employer shall commence the safety equipment improvements or acquisitions within thirty days of the loan approval and shall complete the improvements or acquisitions within ninety days of the loan approval, unless expressly provided otherwise in the loan agreement. The bureau shall verify that the loan proceeds are being used for the purpose approved in the loan application and shall have the right to inspect the employer's workplace for this purpose. The bureau may use the technical assistance of the Division of Safety and Hygiene for such an assessment.
9. Any employer who uses loan proceeds for purposes other than the approved alterations or acquisitions shall be penalized as follows:
   a. The employer shall pay an interest penalty that is provided for in the loan agreement at current market rates for this type of loan;
   b. The bureau may declare all unpaid installments immediately due and payable;
   c. The employer shall not be eligible for another loan for a period of five years from the date of the loan termination.

I. Occupational safety loan review committee
   1. The bureau shall establish an occupational safety loan review committee for the purpose of reviewing applications for loans from the occupational safety loan fund.
   2. The committee shall consist of the superintendent of the Division of Safety and Hygiene, the controller of the Bureau of Workers' Compensation, and a legal representative from the bureau.
   3. The committee shall consider each loan application individually and make a recommendation to the administrator of the Bureau of Workers' Compensation either to approve or to deny the application.
   4. The committee shall meet once each month.
   5. Complete, accurate applications shall be considered within thirty days of receipt.

J. If the aggregate value of loan applications is greater than the assets available from the fund, the administrator shall take into account the following factors to determine whether an employer will be granted a loan:
   1. Employers with no prior loan applications or outstanding loans shall have priority over employers with loans outstanding.
   2. Employers with greater capacity to repay loans or an exemplary credit record shall be given primary consideration.
   3. No loans shall be made which will cause the fund to operate at a deficit.

K. The Bureau of Workers' Compensation shall be responsible for collecting repayments on loans, and shall maintain an accounting record for such purposes.

L. Appeal
   1. An employer may appeal, in writing, the denial of a loan application and request reconsideration of the application, without additional fees, within thirty days of notification of the denial.
   2. An appeal of a denial based on technical reasons shall be reviewed by a committee consisting of the superintendent of the Division of Safety and Hygiene, the assistant superintendent for technical information, the appropriate division regional manager, and a professional engineer.
   3. An appeal of a denial based on financial reasons shall be reviewed by the occupational safety loan review committee.
   4. At the time of appeal, the employer shall provide additional documentation that will demonstrate that the denial was not justified.

5. The appropriate review committee shall consider the original loan application, together with the additional documentation, and make a recommendation to the administrator of the Bureau of Workers' Compensation either to approve or to re-deny the application.
6. The decision of the administrator on an appeal shall be final.

4123-17-32 Self-Insuring employer assessments based upon paid compensation
eff. 07/01/02

The administrator of workers' compensation, with the advice and consent of the workers' compensation oversight commission, has authority to determine and levy against self-insuring employers amounts to be paid to support the safety and hygiene fund, the administrative cost fund, the portion of the surplus fund that is mandatory, the portion of the surplus fund that is used for rehabilitation reimbursement subject to the self-insuring employer's election under section 4121.66 of the Revised Code, and the portion of surplus fund that is used for handicap reimbursement subject to the self-insuring employer's election under section 4123.343 of the Revised Code, pursuant to sections 4121.12, 4121.37, 4121.66, 4123.34, 4123.342, and 4123.35 of the Revised Code in conjunction with rule 4123-19-01 of the Administrative Code. The administrator hereby sets the self-insuring employer assessments to be effective July 1, 2002, for the period July 1, 2002, to June 30, 2003, payable in two equal remittances by February 28, 2003, and August 31, 2003, as follows:

A. The assessments shall be on the basis of the paid compensation attributable to the individual self-insuring employer as a fraction of the total amount of paid compensation for the previous calendar year attributable to all amenable self-insuring employers.
B. Paid compensation means all amounts paid by a self-insuring employer for living maintenance benefits, all amounts for compensation paid pursuant to sections 4121.63, 4121.67, 4123.56, 4123.57, 4123.58, 4123.59, 4123.60 and 4123.64 of the Revised Code, all amounts paid as wages in lieu of such compensation, all amounts paid in lieu of such compensation under a nonoccupational accident and sickness program fully funded by the self-insuring employer, and all amounts paid by a self-insuring employer for a violation of a specific safety standard pursuant to section 35 of article II, Ohio Constitution and section 4121.47 of the Revised Code. Any reimbursement received from the surplus fund pursuant to section 4123.512 of the Revised Code by a self-insuring employer for any such payments or compensation paid shall be applied to reduce the amount of paid compensation reported in the year in which the reimbursement is made. Any amount recovered by the self-insuring employer under section 4123.93 of the Revised Code and any amount that is determined not to have been payable to a claimant in any final administrative or judicial proceeding shall be deducted, in the year collected, from the amount of paid compensation reported.
C. The assessments shall be computed for all self-insuring employers operating in Ohio by multiplying the following rates by the individual self-insuring employer's paid compensation for calendar year 2001:

	Rate
Safety and hygiene fund	.0098
Administrative cost fund	.1606
Surplus fund (mandatory)	.0415

D. The assessment to fund the portion of the surplus fund that is used for rehabilitation reimbursement for all self-insuring employers who have not made an election to opt out of the rehabilitation reimbursement program under the provisions of section 4121.66 of the Revised Code shall be computed by multiplying the following rate by the individual self-insuring employer's paid compensation for calendar year 2001:

	Rate
Surplus fund (rehabilitation)	.1300

E. The assessment to fund the portion of the surplus fund that is used for handicap reimbursement for all self-insuring employers operating in Ohio who have not made an election to opt out of the handicap reimbursement program under the provisions of division (G) of section 4123.343 of the Revised Code shall be computed by multiplying the following rate by the individual self-insuring employer's paid compensation for calendar year 2001:

	Rate
Surplus fund (handicap)	.2480

F. An employer who no longer is a self-insuring employer in Ohio or who no longer is operating in this state shall continue to pay assessments for administrative costs and for the portion of the surplus fund that is mandatory. The assessments shall be computed by such employer by multiplying the following rates by the individual employer's paid compensation for calendar year 2001:

	Rate
Administrative cost fund	.1606
Surplus fund (mandatory)	.0415

G. If the paid compensation for a self-insuring employer for calendar year 2001 is less than fourteen thousand one hundred and fifty-seven dollars and sixty two cents, the minimum assessments shall be paid as follows:

	Rate
Safety and hygiene fund	138.75
Administrative cost fund	2,273.71
Surplus fund (mandatory)	587.54

If the paid compensation for calendar year 2001 for a self-insuring employer which has not made an election to opt out of the rehabilitation reimbursement program effective on or before July 1, 2002 is less than fifteen thousand three hundred and eighty four dollars and sixty two cents, the minimum assessment for the surplus fund (rehabilitation) shall be two thousand dollars.

If the paid compensation for calendar year 2001 for a self-insuring employer which has opted to participate in the handicap reimbursement program is less than fifty thousand dollars, the minimum assessment for the surplus fund (handicap) shall be twelve thousand four hundred dollars.

Assessments are applicable only for the funds to which payments must be made based upon the status and the options exercised relative to the handicap reimbursement program and the rehabilitation reimbursement program.

An employer who no longer is a self-insuring employer in Ohio or no longer is operating in this state and who has less than fourteen thousand one hundred fifty seven dollars and sixty two cents in paid compensation for calendar year 2001 shall have a reduced minimum assessment. The minimum assessment shall be ninety per cent of the above minimum assessments in this paragraph in the year after becoming inactive, eighty per cent in the following year, seventy per cent in the following year, and so forth, being reduced ten per cent each year, until the assessment is phased out over ten years.

H. If an individual self-insuring employer has become self-insured in the last five years (on or after July 1, 1997) paid compensation shall be as defined in paragraph (B) of this rule and shall additionally include compensation paid in calendar year 2001 by the state insurance fund for claim costs directly attributable to the employer prior to becoming self-insured.

I. The initial assessment to a self-insuring employer in its first calendar year of operation as a self-insuring employer shall be prorated to cover the time period that self-insurance was in effect, but shall not be less than the minimum assessment for a self-insuring employer as provided in paragraph (G) of this rule.

J. Pursuant to rule 4123-19-15 of the Administrative Code, the following assessment, to be billed and collected as a single assessment in October 2002, shall be computed for all self-insuring employers by multiplying the following rate by the individual self-insuring employer's paid compensation for calendar year 2001:

	Rate
Self-insuring employer guaranty fund	.0000

4123-17-35 Public employer state agency contribution to the state insurance fund
eff. 7/01/02

The administrator of workers' compensation, with the advice and consent of the workers' compensation oversight commission, has authority to approve contributions made to the state insurance fund by employers pursuant to sections 4121.121, 4123.39, and 4123.40 of the Revised Code. The administrator hereby sets rates per one hundred dollar unit of payroll to be effective July 1, 2002, applicable to the payroll reporting period July 1, 2002, through June 30, 2003, for public employer state agencies, including state universities and university hospitals, as indicated in the attached appendix A.

4123-17-36 Administrative cost contribution
eff. 07/01/02

A. The administrator of workers' compensation, with the advice and consent of the workers' compensation oversight commission, has authority to calculate contributions to the administrative cost fund by employers pursuant to sections 4121.121, 4123.341, and 4123.342 of the Revised Code. The administrator hereby sets administrative cost rates as indicated in paragraph D of this rule.
B. The administrative cost rate for each employer's assessment, except for self-insuring employers, is calculated as follows:
   1. If the employer qualifies for experience rating either as an individual or through participation in group rating, the assessment is calculated based on a percentage of the employer's experience rated premium.
   2. If the employer is not experience rated, the assessment is calculated based on a percentage of the employer's base rate premium.
   3. If the employer is retrospectively rated, the assessment is calculated based on a percentage of the employer's experience rated premium or base rated premium (but not the minimum premium percentage from the retrospective rating plan) that the employer would have paid if the employer were not participating in retrospective rating.
   4. For state agencies, including state universities and state university hospitals, the assessment is calculated based on a percentage of the employer's premium.
C. Whenever administrative cost rates established under this rule and rule 4123-17-32 of the Administrative Code prove inadequate or excessive, the same may be adjusted at any time during the biennial period.
D. Administrative cost rates.
   1. Private employers19.50 percent of premium effective July 1, 2002.
   2. Public employer taxing districts: 16.65 percentof premium effective January 1, 2002.
   3. Public employer state agencies: 21.91 percent of premium effective July 1, 2002.

4123-17-37 Employer contribution to the Safety and Hygiene Fund
eff. 07/01/99

The Administrator of Workers' Compensation, with the advice and consent of the workers' compensation oversight commission, has authority to approve contributions to the State Insurance Fund by employers pursuant to Sections 4121.121 and 4121.37 of the Revised Code. The administrator hereby establishes the amount of premium to be set aside to fund the Division of Safety and Hygiene to be one percent of paid premium for public employer taxing districts and public employer state agencies, and one percent of paid premium for private employers.

4123-17-38 Private employer contribution to the Premium Payment Security Fund
eff. 07/01/92

The Workers' Compensation Board, exercising its authority to approve contributions to the State Insurance Fund by employers pursuant to Sections 4121.12 and 4121.34 of the Revised Code, hereby establishes the amount of premium to be set aside for the Premium Payment Security Fund at one half of one percent of paid premium.

4123-17-40 Self-Insured buy-out factors
eff. 07/01/98

The administrator of workers' compensation, with the advice and consent of the workers' compensation oversight commission, has authority to establish factors for the purpose of implementing the procedure for Self-Insurance buy-outs. The administrator hereby adopts factors to establish the liability of a private employer or a public taxing district employer requesting to transfer from State Insurance Fund coverage to self-insurance with the buy-out calculated upon the pure premium paid by the employer on payroll for a seven calendar year period, as provided in paragraph (M) of rule 4123-19-03 of the Administrative Code. The factors indicated in Appendix A below, shall apply to appropriate applications filed on or after July 1, 1998.

APPENDIX A

Calendar Year	Buyout Percentage: Private Employers	Buyout Percentage: Public Employer Taxing Districts
For all seven years of buy-out calculation	0.0%	0.0%

4123-17-41 Retrospective rating definitions applicable to any employer
eff. 07/01/97

As used in rules 4123-17-41 to 4123-17-54 of the Administrative Code:

A. “Minimum premium” means the fixed cost chargeable to an employer, independent of the claims costs of the employer during the year of experience.
B. “Maximum premium” means the employer’s experience-rated premium multiplied by the maximum premium percentage selected by the employer.
C. “Per claim limit” means maximum chargeable costs for each claim incurred during the retrospective-rated period, as selected by the employer.
D. “Retrospective policy year "or" policy year” means the fiscal year beginning July first for private employers and the calendar year beginning January first for the public employer taxing districts.
E. “Evaluation period” means the ten-year period beginning with the first day of the policy year. Annual evaluations will occur throughout the evaluation period. At the end of the evaluation period, final settlement will be made.
F. “Final settlement” means the final determination of premium for a policy year including any remaining reserves for claims occurring in the policy year. This determination will occur at the end of the evaluation period and will terminate the plan for that policy year.
G. “Annual evaluation” means a statement of claim costs and premium. This information will be shown on the “Retrospective Rating Policy Year Statement.”
H. “Incurred losses” are compensation awards, medical payments, reserves and present values. Reserves will be assigned at the end of the evaluation period. Present values will be assigned to permanent total disability claims and death claims and charged to the employer as incurred.
I. "Retrospective Premium" means the compilation of minimum premium, all medical costs, indemnity, and any remaining reserves at the end of the ten year liability.

4123-17-42 Eligibility for retrospective rating
eff. 07/01/97

A. An employer may be eligible for either the Tier I or Tier II retrospective rating plan depending upon satisfying the eligibility requirements for either the Tier I or Tier II retrospective rating plan as described in this rule.
B. For both the Tier I and Tier II retrospective rating plans, the employer must satisfy the following requirements:
   1. The employer must be current on any and all undisputed premiums, administrative costs, assessments, fines or moneys otherwise due to any fund administered by the Ohio Bureau of Workers' Compensation, including amounts due for retrospective rating.
   2. The employer cannot have any unpaid audit findings or other unpaid billings as of the application deadline.
   3. The employer cannot have cumulative lapses in workers' compensation coverage in excess of fifteen days within the last five rating years.
   4. The employer must be in an active status on the first day of the policy year. The administrator may waive this requirement for new business entities moving into Ohio.
   5. The employer's estimated experience-rated premium for the retrospective rating year must be greater than or equal to the minimum experience-rated premium threshold listed on the "Retrospective Rating Minimum Premium Percentages Table. If estimated premium is less than the minimum experience-rated premium threshold listed on the "Retrospective Rating Minimum Premium Percentages Table," the bureau will reject the application. In the event the estimated experience-rated premium is equal to or greater than the minimum premium threshold but the actual premium is less than the minimum experience-rated premium threshold, the retrospective rating plan remains in effect for that risk and the minimum premium is based on the experience-rated premium threshold multiplied by the appropriate minimum premium percentage for the hazard group and the claim limit/maximum premium percentage selected.

C. In addition to the requirements of paragraph (B) of this rule, for the Tier I retrospective rating plan, the employer must satisfy the following requirements:
   1. The employer must satisfy financial standards demonstrating strength and stability. In reviewing the financial requirements of the employer, the bureau shall consider, but is not limited to, the following criteria, as applicable:
      a. The employer's trend of operating profit for a minimum of three years.
      b. The employer's trend of net income for a minimum of five years.
      c. The employer's consistent return on equity, of ten per cent or better.
      d. Significant asset size of the employer in the state of Ohio.
      e. A total liabilities/equity ratio of no greater than four to one.
      f. The employer's debt structure, including current versus long term debt, recent drastic changes in debt, etc.
      g. The employer's retained earnings trend.
      h. Whether the employer has significant fluctuations in specific balance sheet numbers from one year to the next.
      i. The employer's bond rating.
   2. The employer shall demonstrate that if it sustains a catastrophic or severe workers' compensation loss, it has the ability to maintain its financial viability and to cover all costs of the retrospective rating plan through closure.
   3. The employer shall maintain a safety program approved by the bureau's division of safety and hygiene.
   4. The employer cannot have entered into a part-pay agreement for payment of assessments due the state insurance fund for the past three rating years preceding the beginning date of the retrospective policy year.

D. In addition to the requirements of paragraph (B) of this rule, for the Tier II retrospective rating plan, the employer must satisfy the following requirements:
   1. For an employer that does not demonstrate the ability to satisfy the financial criteria of paragraph (C)(1) of this rule, the employer must demonstrate the ability to sustain losses that are at the maximum claim limit for the retrospective rating plan and still maintain its financial viability.
   2. Within one year of entering a retrospective rating plan, the employer must implement the bureau's ten-step business plan as defined in rule 4123-17-70 of the Administrative Code.. The employer must agree to meet quarterly with a bureau representative to discuss the retrospective rating program and to discuss risk management strategies that other employers are successfully using to control their workers' compensation costs.

E. An employer participating in a retrospective rating plan prior to July 1, 1997, shall operate under the requirements of the Tier II retrospective rating plan, but the bureau shall calculate the employer's premiums in accordance with the tables for Tier I retrospective rating plan.

4123-17-43 Application for retrospective rating plan
eff. 07/01/97

A. The application for any retrospective rating plan is optional with the employer, subject to acceptance by the Ohio Bureau of Workers' Compensation.
B. All operations of a risk electing retrospective rating are subject to retrospective rating.
C. Application must be filed on a bureau form provided for the application for the retrospective rating plan. The application must be completed in its entirety, including but not limited to the selection of a per-claim limit and maximum premium percent. The absence of pertinent information will result in the application being rejected.
D. The written application must be filed with the Ohio Bureau of Workers' Compensation ninety days preceding the beginning date of the policy year. An application for a retrospective rating plan is applicable to only one policy year. Continuation of a plan for subsequent years is subject to filing of an application on a yearly basis and the meeting of eligibility requirements each year.
E. The application may be filed in any office (central or service) of the Ohio Bureau of Workers' Compensation.
F. All changes to the original application must be filed on a new bureau form provided for the application for the retrospective rating plan and must be filed prior to the filing deadline. Any rescissions made must be completed in writing, signed by an officer of the company, and be filed prior to the filing deadline. This filing deadline is the same as the deadline for filing an application for a retrospective rating plan. Any changes received by the Bureau of Workers' Compensation after the filing deadline will not be honored. The latest application form or rescission received by the bureau prior to the filing deadline will be used in determining the premium obligation.

4123-17-44 Minimum premium
eff. 10/02/90

A. The minimum annual premium due the fund shall not be less than the minimum experience-rated premium threshold times the appropriate minimum premium percentage for the hazard group and the claim limit/maximum premium percentage selected for the specified policy year under review.
B. If estimated experience-rated premium is greater than or equal to the minimum experience-rated premium threshold listed on the "Retrospective Rating Minimum Premium Percentages Table" but actual experience-rated premium is less than the minimum experience-rated premium threshold listed, the employer remains retrospective-rated. The minimum premium due would be the minimum experience-rated premium threshold times the appropriate minimum premium percentage for the hazard group and the claim limit/maximum premium percentage selected.
C. The minimum annual premium is due and payable even if the employer has no claims costs during the evaluation period for the specified policy year under review.
D. The minimum premium will not be prorated. The minimum annual premium is due and payable if the employer has elected to be retrospective-rated, the employer has been approved for retrospective rating by the Ohio Bureau of Workers' Compensation, and the filing deadline has expired.

4123-17-45 Initial computation
eff. 07/01/97

A. The hazard group for an employer shall be determined as follows. The employer's experience-rated premium for the policy year shall be allocated to the ten industry groups used in experience rating as provided in appendix B, (Table 1, Part B), of Rule 4123-17-05 of the Administrative Code. The industry group producing the most premium shall be used to determine the hazard group, unless that industry group is group ten; in the latter case, the industry group producing the second highest premium shall be used, unless its premium is less than ten percent. Industry group ten is the determining industry group only if it has the largest premium and no other industry group has ten percent of the premium If the determining industry group is two, four, five, or ten, the hazard group shall be A. If the determining industry group is six, seven, or nine, the hazard group shall be B. If the determining industry group is one or three, the hazard group shall be C. If the determining industry group is eight, the hazard group shall be D. For all public employer taxing districts, the hazard group shall be that group specifically developed for such employers and as shall be periodically established by the administrator with the advice and consent of the workers' compensation oversight commission.
B. The Ohio Bureau of Workers' Compensation shall notify the employer of the estimated minimum premium percentage based on the limits selected by the employer and the payroll of the employer. The premium rates on the payroll reports received by the employer for the policy year will be calculated using the minimum premium percent.

4123-17-46 Premium adjustments
eff. 07/01/94

A. Upon completion of a policy year and annually throughout the evaluation period, the employer's aggregate retrospective-rated premium for the policy year will be determined based on the incurred losses and on the audited payrolls of the employer. The Ohio Bureau of Workers' Compensation shall annually send the employer a "Retrospective Rating Policy Year Statement" within approximately four months following the end of the policy year.
B. Incurred losses will be based on compensation awards and medical payments. Present values of permanent total disability claims and death claims will be calculated and included in the losses as the awards are made.
C. If the retrospective premium due is less than the retrospective premium paid as of the prior evaluation date, the difference, subject to the minimum premium, less assessments due any fund administered by the Ohio Bureau of Workers' Compensation will be refunded to the employer.
D. If the retrospective premium due is greater than the retrospective premium paid as of the prior evaluation date, the difference must be paid to the State Insurance Fund within thirty days after the date of the mailing of the notice that premium is due or the employer will be subject to penalties as provided in rule 4123-17-48 of the Administrative Code.
E. Values used in the annual evaluation will not be revised for any reason other than clerical error. The Ohio Bureau of Workers' Compensation must be notified of any such errors, in writing, within sixty days after the mailing of

the Retrospective Rating Policy Year Statement.

F. Premiums are subject to minimum and maximum premium limitations as selected by the employer.

4123-17-47 Final settlement

eff. 10/02/90

A. At the end of the tenth-year determination of retrospective premium, the plan for that retrospective policy year shall terminate.

B. As part of the final determination of retrospective premium, the Ohio Bureau of Workers' Compensation will evaluate the employer's claims and establish reserves. Reserves will be developed for claims, other than allowed permanent total disability claims and allowed death claims, using the balance sheet reserve table in effect as of the ending date of the evaluation period.

C. The Ohio Bureau of Workers' Compensation will notify the employer of the reserve balances which will be reflected on the "Retrospective Rating Policy Year Statement".

D. The final settlement calculated, subject to the minimum and maximum premium of the plan selected, shall be paid to the Ohio Bureau of Workers' Compensation within thirty days after the date of the mailing of the notice that premium is due.

E. The final determination of a retrospective premium will not be revised for any reason other than clerical error.

4123-17-48 Penalties

eff. 7/01/94

A. Any retrospective rated employer failing to file a report of payroll expenditures or failing to pay premium when due, as prescribed in rules 4123-17-46 and 4123-19-07 of the Administrative Code, will be penalized in accordance with paragraph (C) of rule 4123-19-07 of the Administrative Code if the employer is a private employer or paragraph (F) of rule 4123-19-07 of the Administrative Code if the employer is a county or public employer taxing district. All premium due as a result of the selection of retrospective rating, including the minimum premium and premium as a result of annual evaluations, shall be included as premium as used in this rule.

B. Any employer that is not current on any and all undisputed premiums, administrative costs, assessments, fines or monies otherwise due to any fund administered by the Ohio Bureau of Workers' Compensation, including amounts due for retrospective rating, will not be eligible for retrospective rating in future policy years as long as monies have not been remitted.

4123-17-49 Handicap reimbursement

eff. 10/02/90

A. Handicap relief will be applied to reducible claims costs as limited by the per-claim limit selected by the employer.

B. Rule 4121-03-28 of the Administrative Code will also apply to retrospective rated employers.

4123-17-50 Catastrophes

eff. 10/02/90

A. A "Catastrophe" is defined as an occurrence in which two or more employees of one employer are killed or receive injuries resulting in permanent and total disability.

B. "Catastrophe cost" is defined as the total medical payments, compensation awards, present values and reserves for future costs, as a direct result of a catastrophe.

C. Catastrophe cost in excess of the catastrophe value from part A of the "Experience-Rated Credibility Table" shall not be included in the experience of a classification or of an employer.

D. Catastrophe cost in excess of the catastrophe value from Part A of the "Experience-Rated Credibility Table" in effect for the retrospective policy year shall not be included in the annual evaluation or final settlement of that retrospective policy year.

E. Notwithstanding the provisions of this rule, the Administrator may consider any special circumstances which may affect the determination of a catastrophe loss.

4123-17-51 Termination and transfers
eff. 07/01/97

A. A risk may not retroactively include claims experience in a plan, exclude claims experience from a plan nor voluntarily terminate a plan during the evaluation period.

B. Successor: retrospective-rated.
Predecessor: experience-rated, base-rated, non-complying or self-insured.
Where one legal entity that has established coverage and is a retrospective rated employer wholly succeeds one or more legal entities having established coverage and the predecessor entities are either experience-rated, base-rated, non-complying or self-insured at the date of succession, the costs incurred and payroll reported by the predecessor from the date of succession to the end of the policy year, shall be included in the successor's retrospective rating plan. The successor remains liable for any and all charges associated with the predecessor. If the predecessor had at any time participated in a retrospective policy plan, the successor remains liable for any and all charges associated with the retrospective policy plans. The adjustment for combinations in the experience rating system will follow the same rules that are in effect as of the date of succession.

C. Successor: self-insured.
Predecessor: retrospective-rated.
Where one legal entity that has established coverage and is a self-insured employer wholly succeeds one or more entities that are retrospective-rated, the retrospective-rated predecessor's plan(s) shall terminate as of the ending date of the evaluation period. Payroll reported and claims incurred on or after the date of succession will be the responsibility of the successor. The successor shall remain responsible for all liabilities of the predecessor, including but not limited to costs associated with any retrospective policy years still in the evaluation period. The minimum premium for the current policy year will be based upon the predecessor's annualized payroll.

D. Successor: experience-rated or base-rated.
Predecessor: retrospective-rated.
Where one legal entity that has established coverage and is an experience-rated or base-rated employer wholly succeeds one or more entities that are retrospective-rated, the retrospective-rated predecessor's plan(s) shall terminate as of the ending date of the evaluation period. Payroll reported and claims incurred on or after the date of succession will be the responsibility of the successor under its experience rated plan. The successor shall remain responsible for all liabilities of the predecessor, including but not limited to costs associated with any retrospective policy years still in the evaluation period. The minimum premium for the current policy year will be based upon the predecessor's annualized payroll.

E. Successor: retrospective-rated.
Predecessor: retrospective-rated.
If the successor and the predecessor are retrospective-rated employers for the current policy year, the successor shall be retrospective-rated based on the combined experience of the predecessor and the successor. The successor remains liable for any and all retrospective-rated premiums or other charges associated with the predecessor. The adjustment for combinations in the experience rating system will follow the same rules that are in effect as of the date of succession.

F. Successor: entity not having coverage.
Predecessor: retrospective-rated.
When an entity not having coverage wholly succeeds a retrospective-rated entity, the experience of the predecessor shall be transferred to the successor-employer effective as of the actual date of succession. The successor remains liable for any and all open retrospective-rated premium or other charges associated with the predecessor. The successor entity will become retrospective-rated as of the date of succession until the end of the policy year, with the same plan parameters chosen by the predecessor risk. The adjustment for combinations in the experience rating system will follow the same rules that are in effect as of the date of succession.

G. Successor: cancels coverage.
Predecessor: no predecessor.
If a current or previously retrospective-rated employer cancels coverage and does not transfer or combine operations with another entity, all open retrospective policy years will be terminated as of the date of cancellation. If the employer was retrospective-rated during the two most recent rating years, the final premium for each of those years will be the maximum premium for the plan selected by the employer. The maximum premium for the current year will be based upon the employer's annualized payroll. If the employer was retrospective-rated in other years of the evaluation period, the final premium for each of those years will be calculated as stated in rule 4123-17-47 of the Administrative Code.

H. Successor: files a petition for bankruptcy
Predecessor: no predecessor
If a current previously retrospective-rated employer with open policy year(s) files a petition for bankruptcy under chapter 7 or chapter 11 of the Federal Bankruptcy Law, the employer shall notify the bureau of workers' compensation law section by certified mail within five working days from the date of the bankruptcy filing. The bureau will petition the bankruptcy court to take e appropriate action to protect the health of the state insurance fund and other related funds.

I. Successor and/or predecessor: open retrospective -rated policy years in the evaluation period
If the successor and predecessor employers are not currently retrospective-rated but either or both have open retrospective-rated policy years in the evaluation period, the successor shall be liable for any and all retrospective-rated premiums or other charges associated with the predecessor. The adjustment for combinations in the experience rating system will follow the same rules that are currently being used.

J. Partial transfer
If an entity partially succeeds another entity and the predecessor entity has any retrospective policy years in the evaluation period, the predecessor entity remains liable for all premium associated with claims incurred prior to the date of the partial transfer. If the financial capability of the predecessor entity is not sufficient to cover the costs of the retrospective rating plan, the successor shall be liable for all unpaid costs of the predecessor's retrospective rating plan through closure. If the successor is retrospective-rated in the current policy year and the effective date of the partial transfer is other than the beginning of the policy year, the successor will continue to be retrospective-rated until the end of the policy year. If the successor is not retrospective-rated in the current policy year and the effective date of the transfer is other than the beginning of the rating year, the successor will continue to be rated in the same manner as prior to the transfer. The successor will be liable for any payroll and/ or claims incurred from that part of the predecessor entity which was transferred, beginning on the date of the transfer. Within ninety days of the partial transfer, the predecessor shall settle with the bureau all liabilities including all medical costs associated with the predecessor's qualified health plan, associated with that part of the business being transferred for year(s) still in the evaluation period. The adjustment for partial transfers in the experience rating system will follow the same rules that are in effect as of the date of succession.

K. Transfer or sale of assets only
In the case of the transfer or sale of assets without transfer of liability or stock, the transferor who is now retrospective-rated or has been retrospective-rated with policy year(s) still in the evaluation period shall notify the Ohio bureau of workers' compensation actuarial section by certified mail within five working days of the date of transfer. The bureau shall schedule and hold a hearing within sixty days of such notification, or in the event of no notification, within sixty days of receiving information which indicates such a transfer may have occurred. At this hearing the bureau shall determine and set responsibility for funding the as yet unpaid costs associated with the retrospective policy year(s) still in the evaluation period.

4123-17-52 Parameters of the retrospective rating plan
eff. 07/01/97

A. An employer participating in retrospective-rating will pay the following:
   1. Minimum premium. The minimum premium depends on the hazard group, the per claim limit selected by the employer, the maximum premium limit selected by the employer, and the employer’s base-rated premium or experience-rated premium. The employer’s base-rated premium or experience-rated premium is assumed to be at least the minimum experience-rated/base-rated premium threshold listed on the “Retrospective Rating Minimum Premium Percentages Table”. The minimum premium includes employer contributions to cover safety and hygiene costs, surplus costs, premium payment security costs, and the cost of losses exceeding the per claim and the maximum premium limitations.
   2. Premium based on paid or awarded losses. The employer will pay for any compensation awards, including death and permanent total disability, and medical payments made in covered claims. Billings to the employer will be sent annually for ten years to collect for paid or awarded losses.
   3. Premium based on reserves. The employer will pay the value of reserves on claims evaluated as of the end of the tenth year.

B. Surplus charges in claims will not be charged to the employer.

C. Individual claims costs will be limited to the per claim limit selected by the employer. The usual experience rating limitations will not apply.

D. The employer’s maximum premium will be limited to a percentage of its base-rated premium or experience-rated premium as selected by the employer. That is, premiums based on losses and reserves charged to the employer cannot exceed the maximum premium minus the minimum premium.

E. When an employer leaves a retrospective rating program and returns to the State Fund Program, the employer shall be subject to all of the provisions of rule 4123-17-03 of the Administrative Code, classification rates.

4123-17-53 Private employer retrospective rating plan minimum premium percentages.
eff. 07/01/97

The Administrator of Workers' Compensation, with the advice and consent of the Workers' Compensation Oversight Commission, has the authority to approve contributions made to the state insurance fund by employers pursuant to sections 4121.121, 4121.13, 4121.30, 4123.29, and 4123.34 of the Revised Code. The Administrator hereby sets the private employer retrospective rating plan minimum premium percentages to be effective for July 1, 1997 policy year as indicated in the attached Appendixes A (Tier I, Table A, B, C, and D) and B (Tier II, Tables A, B, C, and D).

Appendix A
Tier I

Retrospective Rating
Minimum Premium Percentages
Private Employer – Hazard Group A

Premium Range	$100,000 Claim Limit		$125,000 Claim Limit		$250,000 Claim Limit		$300,000 Claim Limit		No Claim Limit	
	150%	200%	150%	200%	150%	200%	150%	200%	150%	200%
25,000 – 29,999	0.91	0.78	0.91	0.78	0.91	0.78	0.91	0.78	0.91	0.78
30,000 – 34,999	0.88	0.75	0.88	0.75	0.88	0.75	0.88	0.75	0.88	0.75
35,000 – 39,999	0.85	0.72	0.85	0.72	0.85	0.72	0.85	0.72	0.85	0.72
40,000 – 44,999	0.83	0.70	0.83	0.70	0.83	0.70	0.83	0.70	0.83	0.70
45,000 – 49,999	0.81	0.68	0.81	0.68	0.81	0.68	0.81	0.68	0.81	0.68
50,000 – 54,999	0.79	0.66	0.79	0.66	0.79	0.66	0.79	0.66	0.79	0.66
55,000 – 59,999	0.78	0.65	0.78	0.64	0.78	0.64	0.78	0.64	0.78	0.64
60,000 – 64,999	0.76	0.64	0.76	0.63	0.76	0.63	0.76	0.63	0.76	0.63
65,000 – 69,999	0.75	0.64	0.75	0.62	0.75	0.62	0.75	0.62	0.75	0.62
70,000 – 74,999	0.74	0.63	0.74	0.62	0.74	0.60	0.74	0.60	0.74	0.60
75,000 – 79,999	0.73	0.62	0.73	0.61	0.73	0.59	0.73	0.59	0.73	0.59
80,000 – 84,999	0.72	0.61	0.72	0.60	0.72	0.58	0.72	0.58	0.72	0.58
85,000 – 89,999	0.71	0.61	0.72	0.59	0.71	0.57	0.71	0.57	0.71	0.57
90,000 – 94,999	0.70	0.60	0.70	0.59	0.70	0.56	0.70	0.56	0.70	0.56
95,000 – 99,999	0.70	0.60	0.69	0.58	0.69	0.55	0.69	0.55	0.69	0.55
100,000 – 112,499	0.69	0.59	0.68	0.57	0.68	0.54	0.68	0.54	0.68	0.54
112,500 – 124,999	0.67	0.58	0.66	0.56	0.66	0.52	0.66	0.52	0.66	0.52
125,000 – 137,499	0.66	0.57	0.65	0.55	0.64	0.51	0.64	0.51	0.64	0.51
137,500 – 149,999	0.65	0.56	0.64	0.54	0.63	0.49	0.63	0.49	0.63	0.49
150,000 – 162,499	0.64	0.56	0.63	0.53	0.62	0.48	0.62	0.48	0.62	0.48
162,500 – 174,999	0.63	0.55	0.62	0.53	0.61	0.48	0.61	0.47	0.61	0.47
175,000 – 187,499	0.62	0.55	0.61	0.52	0.60	0.47	0.60	0.46	0.60	0.46
187,500 – 199,999	0.62	0.54	0.60	0.52	0.59	0.46	0.59	0.46	0.59	0.45
200,000 – 224,999	0.61	0.54	0.59	0.51	0.58	0.45	0.57	0.45	0.57	0.44
225,000 – 249,999	0.60	0.53	0.58	0.50	0.56	0.44	0.56	0.43	0.56	0.42
250,000 – 299,999	0.58	0.53	0.57	0.49	0.54	0.43	0.54	0.42	0.54	0.41
300,000 – 349,999	0.57	0.52	0.55	0.48	0.52	0.41	0.52	0.40	0.52	0.39
350,000 – 399,999	0.56	0.51	0.54	0.48	0.51	0.40	0.50	0.39	0.50	0.37
400,000 – 499,999	0.55	0.51	0.53	0.47	0.49	0.39	0.48	0.38	0.48	0.35
500,000 – 999,999	0.53	0.51	0.50	0.47	0.44	0.36	0.44	0.34	0.42	0.30
1,000,000 – 1,999,999	0.52	0.52	0.49	0.47	0.40	0.36	0.39	0.33	0.36	0.25
2,000,000 – 2,999,999	0.52	0.52	0.48	0.47	0.39	0.36	0.37	0.33	0.33	0.24
3,000,000 – 3,999,999	0.52	0.52	0.48	0.47	0.38	0.36	0.36	0.33	0.31	0.23
4,000,000 – 4,999,999	0.52	0.52	0.47	0.47	0.37	0.36	0.35	0.33	0.30	0.23
5,000,000 – 5,999,999	0.52	0.52	0.47	0.47	0.37	0.36	0.35	0.33	0.30	0.22
6,000,000 – 6,999,999	0.52	0.52	0.47	0.47	0.37	0.36	0.35	0.33	0.29	0.22
7,000,000 – 7,999,999	0.52	0.52	0.47	0.47	0.36	0.36	0.35	0.33	0.29	0.22
8,000,000 – 8,999,999	0.52	0.52	0.47	0.47	0.36	0.35	0.34	0.33	0.28	0.22
9,000,000 – 9,999,999	0.52	0.52	0.47	0.47	0.36	0.35	0.34	0.33	0.28	0.22
10,000,000 – 10,999,999	0.52	0.52	0.47	0.47	0.36	0.35	0.34	0.33	0.28	0.22
11,000,000 – 11,999,999	0.52	0.52	0.47	0.47	0.36	0.35	0.34	0.33	0.27	0.22
12,000,000 – 12,999,999	0.52	0.52	0.47	0.47	0.36	0.35	0.34	0.33	0.27	0.22

Appendix A
Tier I

Retrospective Rating
Minimum Premium Percentages
Private Employer – Hazard Group B

Premium Range	$100,000 Claim Limit		$125,000 Claim Limit		$250,000 Claim Limit		$300,000 Claim Limit		No Claim Limit	
	150%	200%	150%	200%	150%	200%	150%	200%	150%	200%
25,000 – 29,999	0.82	0.67	0.82	0.67	0.82	0.67	0.82	0.67	0.82	0.67
30,000 – 34,999	0.79	0.64	0.79	0.64	0.79	0.64	0.79	0.64	0.79	0.64
35,000 – 39,999	0.77	0.61	0.77	0.61	0.77	0.61	0.77	0.61	0.77	0.61
40,000 – 44,999	0.74	0.59	0.74	0.59	0.74	0.59	0.74	0.59	0.74	0.59
45,000 – 49,999	0.72	0.57	0.72	0.57	0.72	0.57	0.72	0.57	0.72	0.57
50,000 – 54,999	0.71	0.55	0.71	0.55	0.71	0.55	0.71	0.55	0.71	0.55
55,000 – 59,999	0.69	0.55	0.69	0.54	0.69	0.54	0.69	0.54	0.69	0.54
60,000 – 64,999	0.68	0.54	0.68	0.53	0.68	0.53	0.68	0.53	0.68	0.53
65,000 – 69,999	0.67	0.53	0.67	0.51	0.67	0.51	0.67	0.51	0.67	0.51
70,000 – 74,999	0.65	0.52	0.65	0.51	0.65	0.50	0.65	0.50	0.65	0.50
75,000 – 79,999	0.64	0.51	0.64	0.50	0.64	0.49	0.64	0.49	0.64	0.49
80,000 – 84,999	0.63	0.51	0.63	0.50	0.63	0.48	0.63	0.48	0.63	0.48
85,000 – 89,999	0.62	0.50	0.62	0.49	0.62	0.47	0.62	0.47	0.62	0.47
90,000 – 94,999	0.62	0.49	0.62	0.48	0.62	0.47	0.62	0.47	0.62	0.47
95,000 – 99,999	0.61	0.49	0.61	0.48	0.61	0.46	0.61	0.46	0.61	0.46
100,000 – 112,499	0.60	0.48	0.60	0.47	0.60	0.45	0.60	0.45	0.60	0.45
112,500 – 124,999	0.58	0.47	0.58	0.46	0.58	0.43	0.58	0.43	0.58	0.43
125,000 – 137,499	0.57	0.46	0.57	0.45	0.57	0.42	0.57	0.42	0.57	0.42
137,500 – 149,999	0.56	0.46	0.56	0.44	0.55	0.41	0.55	0.41	0.55	0.41
150,000 – 162,499	0.55	0.45	0.55	0.43	0.54	0.40	0.54	0.40	0.54	0.40
162,500 – 174,999	0.54	0.45	0.54	0.42	0.53	0.39	0.53	0.39	0.53	0.39
175,000 – 187,499	0.54	0.44	0.53	0.42	0.52	0.38	0.52	0.38	0.52	0.38
187,500 – 199,999	0.53	0.44	0.52	0.41	0.51	0.38	0.51	0.37	0.51	0.37
200,000 – 224,999	0.52	0.43	0.51	0.41	0.50	0.37	0.50	0.36	0.50	0.36
225,000 – 249,999	0.51	0.43	0.50	0.40	0.49	0.36	0.49	0.35	0.49	0.35
250,000 – 299,999	0.50	0.42	0.49	0.39	0.47	0.35	0.47	0.34	0.47	0.33
300,000 – 349,999	0.49	0.41	0.47	0.38	0.45	0.33	0.45	0.33	0.45	0.32
350,000 – 399,999	0.48	0.41	0.46	0.38	0.44	0.32	0.44	0.32	0.44	0.31
400,000 – 499,999	0.46	0.41	0.45	0.37	0.42	0.31	0.42	0.30	0.42	0.29
500,000 – 999,999	0.44	0.42	0.42	0.38	0.38	0.30	0.38	0.28	0.37	0.26
1,000,000 – 1,999,999	0.43	0.42	0.40	0.38	0.35	0.30	0.34	0.28	0.33	0.24
2,000,000 – 2,999,999	0.43	0.42	0.39	0.38	0.33	0.29	0.32	0.28	0.30	0.22
3,000,000 – 3,999,999	0.42	0.41	0.39	0.38	0.32	0.29	0.31	0.27	0.29	0.22
4,000,000 – 4,999,999	0.42	0.41	0.38	0.38	0.32	0.29	0.31	0.27	0.28	0.21
5,000,000 – 5,999,999	0.42	0.41	0.38	0.38	0.31	0.29	0.30	0.27	0.28	0.21
6,000,000 – 6,999,999	0.42	0.41	0.38	0.38	0.31	0.29	0.30	0.27	0.27	0.21
7,000,000 – 7,999,999	0.42	0.41	0.38	0.38	0.31	0.29	0.30	0.27	0.27	0.21
8,000,000 – 8,999,999	0.42	0.41	0.38	0.38	0.30	0.29	0.30	0.27	0.27	0.21
9,000,000 – 9,999,999	0.42	0.41	0.38	0.38	0.30	0.29	0.29	0.27	0.26	0.21
10,000,000 – 10,999,999	0.42	0.41	0.38	0.38	0.30	0.29	0.29	0.27	0.26	0.21
11,000,000 – 11,999,999	0.42	0.41	0.38	0.38	0.30	0.29	0.29	0.27	0.26	0.21
12,000,000 – 12,999,999	0.42	0.41	0.38	0.38	0.30	0.29	0.29	0.27	0.26	0.21

Appendix A
Tier I

Retrospective Rating
Minimum Premium Percentages
Private Employer – Hazard Group C

Premium Range	$100,000 Claim Limit		$125,000 Claim Limit		$250,000 Claim Limit		$300,000 Claim Limit		No Claim Limit	
	150%	200%	150%	200%	150%	200%	150%	200%	150%	200%
25,000 – 29,999	0.80	0.66	0.80	0.66	0.80	0.66	0.80	0.66	0.80	0.66
30,000 – 34,999	0.77	0.62	0.77	0.62	0.77	0.62	0.77	0.62	0.77	0.62
35,000 – 39,999	0.74	0.60	0.74	0.60	0.74	0.60	0.74	0.60	0.74	0.60
40,000 – 44,999	0.72	0.58	0.72	0.58	0.72	0.58	0.72	0.58	0.72	0.58
45,000 – 49,999	0.70	0.56	0.70	0.56	0.70	0.56	0.70	0.56	0.70	0.56
50,000 – 54,999	0.68	0.54	0.68	0.54	0.68	0.54	0.68	0.54	0.68	0.54
55,000 – 59,999	0.67	0.53	0.67	0.52	0.67	0.52	0.67	0.52	0.67	0.52
60,000 – 64,999	0.65	0.52	0.65	0.51	0.65	0.51	0.65	0.51	0.65	0.51
65,000 – 69,999	0.64	0.51	0.64	0.50	0.64	0.50	0.64	0.50	0.64	0.50
70,000 – 74,999	0.63	0.50	0.63	0.50	0.63	0.49	0.63	0.49	0.63	0.49
75,000 – 79,999	0.62	0.50	0.62	0.49	0.62	0.48	0.62	0.48	0.62	0.48
80,000 – 84,999	0.61	0.49	0.61	0.48	0.61	0.47	0.61	0.47	0.61	0.47
85,000 – 89,999	0.61	0.48	0.60	0.47	0.60	0.46	0.60	0.46	0.60	0.46
90,000 – 94,999	0.60	0.48	0.59	0.47	0.59	0.45	0.59	0.45	0.59	0.45
95,000 – 99,999	0.59	0.47	0.59	0.46	0.59	0.44	0.59	0.44	0.59	0.44
100,000 – 112,499	0.58	0.46	0.57	0.45	0.57	0.43	0.57	0.43	0.57	0.43
112,500 – 124,999	0.57	0.45	0.56	0.44	0.56	0.42	0.56	0.42	0.56	0.42
125,000 – 137,499	0.55	0.45	0.55	0.43	0.55	0.40	0.55	0.40	0.55	0.40
137,500 – 149,999	0.54	0.44	0.54	0.42	0.53	0.39	0.53	0.39	0.53	0.39
150,000 – 162,499	0.53	0.43	0.53	0.41	0.52	0.38	0.52	0.38	0.52	0.38
162,500 – 174,999	0.53	0.43	0.52	0.41	0.51	0.38	0.51	0.38	0.51	0.37
175,000 – 187,499	0.52	0.42	0.51	0.40	0.50	0.37	0.50	0.37	0.50	0.37
187,500 – 199,999	0.51	0.42	0.50	0.40	0.50	0.36	0.50	0.36	0.50	0.36
200,000 – 224,999	0.50	0.41	0.49	0.39	0.48	0.35	0.48	0.35	0.48	0.35
225,000 – 249,999	0.49	0.40	0.48	0.38	0.47	0.34	0.47	0.34	0.47	0.34
250,000 – 299,999	0.48	0.40	0.47	0.37	0.46	0.33	0.45	0.33	0.45	0.32
300,000 – 349,999	0.47	0.39	0.45	0.36	0.44	0.32	0.44	0.31	0.44	0.31
350,000 – 399,999	0.46	0.38	0.44	0.36	0.42	0.31	0.42	0.30	0.42	0.30
400,000 – 499,999	0.44	0.38	0.43	0.35	0.41	0.30	0.41	0.29	0.41	0.28
500,000 – 999,999	0.42	0.39	0.40	0.35	0.37	0.28	0.37	0.27	0.36	0.25
1,000,000 – 1,999,999	0.41	0.39	0.38	0.35	0.34	0.28	0.34	0.26	0.33	0.23
2,000,000 – 2,999,999	0.40	0.39	0.37	0.35	0.32	0.28	0.31	0.26	0.30	0.22
3,000,000 – 3,999,999	0.39	0.39	0.36	0.35	0.31	0.28	0.30	0.26	0.29	0.22
4,000,000 – 4,999,999	0.39	0.39	0.36	0.35	0.30	0.28	0.30	0.26	0.28	0.22
5,000,000 – 5,999,999	0.39	0.39	0.36	0.35	0.30	0.28	0.29	0.26	0.27	0.22
6,000,000 – 6,999,999	0.39	0.39	0.36	0.35	0.29	0.28	0.29	0.26	0.27	0.22
7,000,000 – 7,999,999	0.39	0.39	0.36	0.35	0.29	0.28	0.28	0.26	0.26	0.22
8,000,000 – 8,999,999	0.39	0.39	0.36	0.35	0.29	0.28	0.28	0.26	0.26	0.22
9,000,000 – 9,999,999	0.39	0.39	0.35	0.35	0.29	0.28	0.28	0.26	0.26	0.22
10,000,000 – 10,999,999	0.39	0.39	0.35	0.35	0.29	0.28	0.28	0.26	0.26	0.22
11,000,000 – 11,999,999	0.39	0.39	0.35	0.35	0.29	0.28	0.28	0.26	0.25	0.22
12,000,000 – 12,999,999	0.39	0.39	0.35	0.35	0.29	0.28	0.28	0.26	0.25	0.22

Appendix A
Tier I

Retrospective Rating
Minimum Premium Percentages
Private Employer – Hazard Group D

Premium Range	$100,000 Claim Limit		$125,000 Claim Limit		$250,000 Claim Limit		$300,000 Claim Limit		No Claim Limit	
	150%	200%	150%	200%	150%	200%	150%	200%	150%	200%
25,000 – 29,999	0.78	0.64	0.78	0.64	0.78	0.64	0.78	0.64	0.78	0.64
30,000 – 34,999	0.75	0.61	0.75	0.61	0.75	0.61	0.75	0.61	0.75	0.61
35,000 – 39,999	0.72	0.58	0.72	0.58	0.72	0.58	0.72	0.58	0.72	0.58
40,000 – 44,999	0.70	0.56	0.70	0.56	0.70	0.56	0.70	0.56	0.70	0.56
45,000 – 49,999	0.68	0.54	0.68	0.54	0.68	0.54	0.68	0.54	0.68	0.54
50,000 – 54,999	0.66	0.52	0.66	0.52	0.66	0.52	0.66	0.52	0.66	0.52
55,000 – 59,999	0.65	0.52	0.65	0.51	0.65	0.51	0.65	0.51	0.65	0.51
60,000 – 64,999	0.63	0.51	0.63	0.50	0.63	0.50	0.63	0.50	0.63	0.50
65,000 – 69,999	0.62	0.50	0.62	0.48	0.62	0.48	0.62	0.48	0.62	0.48
70,000 – 74,999	0.61	0.49	0.61	0.48	0.61	0.47	0.61	0.47	0.61	0.47
75,000 – 79,999	0.60	0.48	0.60	0.47	0.60	0.46	0.60	0.46	0.60	0.46
80,000 – 84,999	0.59	0.48	0.59	0.47	0.59	0.45	0.59	0.45	0.59	0.45
85,000 – 89,999	0.58	0.47	0.58	0.46	0.58	0.45	0.58	0.45	0.58	0.45
90,000 – 94,999	0.58	0.46	0.57	0.45	0.57	0.44	0.57	0.44	0.57	0.44
95,000 – 99,999	0.57	0.46	0.57	0.45	0.57	0.43	0.57	0.43	0.57	0.43
100,000 – 112,499	0.56	0.45	0.55	0.44	0.55	0.42	0.55	0.42	0.55	0.42
112,500 – 124,999	0.54	0.44	0.54	0.43	0.54	0.41	0.54	0.41	0.54	0.41
125,000 – 137,499	0.53	0.43	0.53	0.42	0.52	0.39	0.52	0.39	0.52	0.39
137,500 – 149,999	0.52	0.43	0.52	0.41	0.51	0.38	0.51	0.38	0.51	0.38
150,000 – 162,499	0.51	0.42	0.51	0.40	0.50	0.37	0.50	0.37	0.50	0.37
162,500 – 174,999	0.50	0.41	0.50	0.39	0.49	0.37	0.49	0.36	0.49	0.36
175,000 – 187,499	0.50	0.41	0.49	0.39	0.48	0.36	0.48	0.36	0.48	0.36
187,500 – 199,999	0.49	0.40	0.48	0.38	0.48	0.35	0.48	0.35	0.48	0.35
200,000 – 224,999	0.48	0.40	0.47	0.38	0.47	0.34	0.47	0.34	0.47	0.34
225,000 – 249,999	0.47	0.39	0.46	0.37	0.45	0.34	0.45	0.33	0.45	0.33
250,000 – 299,999	0.46	0.39	0.45	0.36	0.44	0.32	0.44	0.32	0.44	0.32
300,000 – 349,999	0.45	0.38	0.44	0.35	0.42	0.31	0.42	0.31	0.42	0.30
350,000 – 399,999	0.44	0.38	0.43	0.35	0.41	0.30	0.41	0.30	0.41	0.29
400,000 – 499,999	0.43	0.37	0.41	0.34	0.39	0.29	0.39	0.29	0.39	0.28
500,000 – 999,999	0.41	0.37	0.39	0.34	0.36	0.28	0.36	0.27	0.36	0.25
1,000,000 – 1,999,999	0.39	0.37	0.37	0.34	0.33	0.27	0.33	0.26	0.32	0.23
2,000,000 – 2,999,999	0.38	0.37	0.36	0.34	0.32	0.27	0.31	0.26	0.30	0.22
3,000,000 – 3,999,999	0.38	0.37	0.35	0.34	0.31	0.27	0.29	0.26	0.28	0.22
4,000,000 – 4,999,999	0.38	0.37	0.35	0.34	0.30	0.27	0.29	0.26	0.27	0.21
5,000,000 – 5,999,999	0.38	0.37	0.35	0.34	0.29	0.27	0.28	0.26	0.27	0.21
6,000,000 – 6,999,999	0.38	0.37	0.35	0.34	0.29	0.27	0.28	0.26	0.26	0.21
7,000,000 – 7,999,999	0.38	0.37	0.35	0.34	0.29	0.27	0.28	0.26	0.26	0.21
8,000,000 – 8,999,999	0.38	0.37	0.35	0.34	0.29	0.27	0.28	0.26	0.26	0.21
9,000,000 – 9,999,999	0.38	0.37	0.35	0.34	0.28	0.27	0.28	0.26	0.26	0.21
10,000,000 – 10,999,999	0.38	0.37	0.35	0.34	0.28	0.27	0.28	0.26	0.25	0.21
11,000,000 – 11,999,999	0.38	0.37	0.35	0.34	0.28	0.27	0.28	0.26	0.25	0.21
12,000,000 – 12,999,999	0.38	0.37	0.35	0.34	0.28	0.27	0.28	0.26	0.25	0.21

Appendix A
Tier I

Retrospective Rating
Minimum Premium Percentages
Public Employer – Taxing Districts

Premium Range	$100,000 Claim Limit		$125,000 Claim Limit		$250,000 Claim Limit		$300,000 Claim Limit		No Claim Limit	
	150%	200%	150%	200%	150%	200%	150%	200%	150%	200%
25,000 – 29,999	0.82	0.70	0.82	0.70	0.82	0.70	0.82	0.70	0.82	0.70
30,000 – 34,999	0.79	0.67	0.79	0.67	0.79	0.67	0.79	0.67	0.79	0.67
35,000 – 39,999	0.77	0.64	0.77	0.64	0.77	0.64	0.77	0.64	0.77	0.64
40,000 – 44,999	0.75	0.61	0.75	0.61	0.75	0.61	0.75	0.61	0.75	0.61
45,000 – 49,999	0.73	0.59	0.73	0.59	0.73	0.59	0.73	0.59	0.73	0.59
50,000 – 54,999	0.71	0.57	0.71	0.57	0.71	0.57	0.71	0.57	0.71	0.57
55,000 – 59,999	0.70	0.57	0.70	0.56	0.70	0.56	0.70	0.56	0.70	0.56
60,000 – 64,999	0.68	0.56	0.68	0.54	0.68	0.54	0.68	0.54	0.68	0.54
65,000 – 69,999	0.57	0.55	0.67	0.53	0.67	0.53	0.67	0.53	0.67	0.53
70,000 – 74,999	0.66	0.54	0.66	0.53	0.66	0.53	0.66	0.53	0.66	0.53
75,000 – 79,999	0.65	0.53	0.65	0.52	0.65	0.50	0.65	0.50	0.65	0.50
80,000 – 84,999	0.64	0.52	0.64	0.51	0.64	0.49	0.64	0.49	0.64	0.49
85,000 – 89,999	0.63	0.52	0.63	0.50	0.63	0.48	0.63	0.48	0.63	0.48
90,000 – 94,999	0.63	0.51	0.62	0.50	0.62	0.48	0.62	0.48	0.62	0.48
95,000 – 99,999	0.62	0.51	0.61	0.49	0.61	0.47	0.61	0.47	0.61	0.47
100,000 – 112,499	0.61	0.50	0.60	0.48	0.60	0.45	0.60	0.45	0.60	0.45
112,500 – 124,999	0.59	0.49	0.59	0.47	0.58	0.44	0.58	0.44	0.58	0.44
125,000 – 137,499	0.58	0.48	0.58	0.46	0.57	0.42	0.57	0.42	0.57	0.42
137,500 – 149,999	0.57	0.47	0.57	0.45	0.56	0.41	0.56	0.41	0.56	0.41
150,000 – 162,499	0.56	0.46	0.56	0.44	0.55	0.40	0.55	0.40	0.55	0.40
162,500 – 174,999	0.56	0.46	0.55	0.43	0.54	0.39	0.54	0.39	0.54	0.39
175,000 – 187,499	0.55	0.45	0.54	0.43	0.53	0.39	0.53	0.38	0.53	0.38
187,500 – 199,999	0.54	0.45	0.53	0.42	0.52	0.38	0.52	0.37	0.52	0.37
200,000 – 224,999	0.53	0.44	0.52	0.42	0.51	0.37	0.51	0.36	0.51	0.36
225,000 – 249,999	0.52	0.44	0.51	0.41	0.49	0.36	0.49	0.35	0.49	0.35
250,000 – 299,999	0.51	0.43	0.50	0.40	0.48	0.34	0.48	0.34	0.48	0.33
300,000 – 349,999	0.50	0.42	0.48	0.39	0.46	0.33	0.46	0.32	0.46	0.31
350,000 – 399,999	0.49	0.42	0.47	0.38	0.45	0.32	0.44	0.31	0.44	0.30
400,000 – 499,999	0.48	0.41	0.46	0.38	0.43	0.31	0.43	0.30	0.42	0.28
500,000 – 999,999	0.45	0.41	0.43	0.38	0.38	0.29	0.38	0.27	0.37	0.24
1,000,000 – 1,999,999	0.44	0.42	0.40	0.38	0.35	0.28	0.34	0.26	0.33	0.21
2,000,000 – 2,999,999	0.43	0.42	0.39	0.38	0.33	0.28	0.32	0.26	0.30	0.19
3,000,000 – 3,999,999	0.42	0.42	0.39	0.38	0.32	0.28	0.30	0.25	0.28	0.18
4,000,000 – 4,999,999	0.42	0.42	0.38	0.38	0.31	0.28	0.30	0.25	0.27	0.18
5,000,000 – 5,999,999	0.42	0.42	0.38	0.38	0.31	0.28	0.29	0.25	0.26	0.17
6,000,000 – 6,999,999	0.42	0.42	0.38	0.38	0.30	0.27	0.29	0.25	0.26	0.17
7,000,000 – 7,999,999	0.42	0.42	0.38	0.38	0.30	0.27	0.28	0.25	0.26	0.17
8,000,000 – 8,999,999	0.42	0.42	0.38	0.38	0.30	0.28	0.28	0.25	0.25	0.17
9,000,000 – 9,999,999	0.42	0.42	0.38	0.38	0.29	0.28	0.28	0.25	0.25	0.17
10,000,000 – 10,999,999	0.42	0.42	0.38	0.38	0.29	0.28	0.28	0.25	0.25	0.17
11,000,000 – 11,999,999	0.42	0.42	0.38	0.38	0.29	0.28	0.28	0.25	0.25	0.17
12,000,000 – 12,999,999	0.42	0.42	0.38	0.38	0.29	0.28	0.28	0.25	0.25	0.17

Appendix B
Tier II

Retrospective Rating
Minimum Premium Percentages
Private Employer – Hazard Group A

Premium Range	$100,000 Claim Limit 150%	$125,000 Claim Limit 150%
25,000 – 29,999	0.91	0.70
30,000 – 34,999	0.88	0.88
35,000 – 39,999	0.85	0.85
40,000 – 44,999	0.83	0.83
45,000 – 49,999	0.81	0.81
50,000 – 54,999	0.79	0.79
55,000 – 59,999	0.78	0.78
60,000 – 64,999	0.76	0.76
65,000 – 69,999	0.75	0.75
70,000 – 74,999	0.74	0.74
75,000 – 79,999	0.73	0.73
80,000 – 84,999	0.72	0.72
85,000 – 89,999	0.71	0.71
90,000 – 94,999	0.70	0.70
95,000 – 99,999	0.70	0.69
100,000 – 112,499	0.69	0.68
112,500 – 124,999	0.67	0.66
125,000 – 137,499	0.66	0.65
137,500 – 149,999	0.65	0.64
150,000 – 162,499	0.64	0.63
162,500 – 174,999	0.63	0.62
175,000 – 187,499	0.62	0.61
187,500 – 199,999	0.62	0.60
200,000 – 224,999	0.61	0.59
225,000 – 249,999	0.60	0.58
250,000 – 299,999	0.58	0.57
300,000 – 349,999	0.57	0.55
350,000 – 399,999	0.56	0.54
400,000 – 499,999	0.55	0.53
500,000 – 999,999	0.53	0.50
1,000,000 – 1,999,999	0.52	0.49
2,000,000 – 2,999,999	0.52	0.48
3,000,000 – 3,999,999	0.52	0.48
4,000,000 – 4,999,999	0.52	0.47
5,000,000 – 5,999,999	0.52	0.47
6,000,000 – 6,999,999	0.52	0.47
7,000,000 – 7,999,999	0.52	0.47
8,000,000 – 8,999,999	0.52	0.47
9,000,000 – 9,999,999	0.52	0.47
10,000,000 – 10,999,999	0.52	0.47
11,000,000 – 11,999,999	0.52	0.47
12,000,000 – 12,999,999	0.52	0.47

Appendix B
Tier II

Retrospective Rating
Minimum Premium Percentages
Private Employer – Hazard Group B

Premium Range	$100,000 Claim Limit 150%	$125,000 Claim Limit 150%
25,000 – 29,999	0.82	0.82
30,000 – 34,999	0.79	0.79
35,000 – 39,999	0.77	0.77
40,000 – 44,999	0.74	0.74
45,000 – 49,999	0.72	0.72
50,000 – 54,999	0.71	0.71
55,000 – 59,999	0.69	0.69
60,000 – 64,999	0.68	0.68
65,000 – 69,999	0.67	0.67
70,000 – 74,999	0.65	0.65
75,000 – 79,999	0.64	0.64
80,000 – 84,999	0.63	0.63
85,000 – 89,999	0.62	0.62
90,000 – 94,999	0.62	0.62
95,000 – 99,999	0.61	0.61
100,000 – 112,499	0.60	0.60
112,500 – 124,999	0.58	0.58
125,000 – 137,499	0.57	0.57
137,500 – 149,999	0.56	0.56
150,000 – 162,499	0.55	0.55
162,500 – 174,999	0.54	0.54
175,000 – 187,499	0.54	0.53
187,500 – 199,999	0.53	0.52
200,000 – 224,999	0.52	0.51
225,000 – 249,999	0.51	0.50
250,000 – 299,999	0.50	0.49
300,000 – 349,999	0.49	0.47
350,000 – 399,999	0.48	0.46
400,000 – 499,999	0.46	0.45
500,000 – 999,999	0.44	0.42
1,000,000 – 1,999,999	0.43	0.40
2,000,000 – 2,999,999	0.43	0.39
3,000,000 – 3,999,999	0.42	0.39
4,000,000 – 4,999,999	0.42	0.38
5,000,000 – 5,999,999	0.42	0.38
6,000,000 – 6,999,999	0.42	0.38
7,000,000 – 7,999,999	0.42	0.38
8,000,000 – 8,999,999	0.42	0.38
9,000,000 – 9,999,999	0.42	0.38
10,000,000 – 10,999,999	0.42	0.38
11,000,000 – 11,999,999	0.42	0.38
12,000,000 – 12,999,999	0.42	0.38

Appendix B
Tier II

Retrospective Rating
Minimum Premium Percentages
Private Employer – Hazard Group C

Premium Range	$100,000 Claim Limit 150%	$125,000 Claim Limit 150%
25,000 – 29,999	0.80	0.80
30,000 – 34,999	0.77	0.77
35,000 – 39,999	0.74	0.74
40,000 – 44,999	0.72	0.72
45,000 – 49,999	0.70	0.70
50,000 – 54,999	0.68	0.68
55,000 – 59,999	0.67	0.67
60,000 – 64,999	0.65	0.65
65,000 – 69,999	0.64	0.64
70,000 – 74,999	0.63	0.63
75,000 – 79,999	0.62	0.62
80,000 – 84,999	0.61	0.61
85,000 – 89,999	0.61	0.60
90,000 – 94,999	0.60	0.59
95,000 – 99,999	0.59	0.59
100,000 – 112,499	0.58	0.57
112,500 – 124,999	0.57	0.56
125,000 – 137,499	0.55	0.55
137,500 – 149,999	0.54	0.54
150,000 – 162,499	0.53	0.53
162,500 – 174,999	0.53	0.52
175,000 – 187,499	0.52	0.51
187,500 – 199,999	0.51	0.50
200,000 – 224,999	0.50	0.49
225,000 – 249,999	0.49	0.48
250,000 – 299,999	0.48	0.47
300,000 – 349,999	0.47	0.45
350,000 – 399,999	0.46	0.44
400,000 – 499,999	0.44	0.43
500,000 – 999,999	0.42	0.40
1,000,000 – 1,999,999	0.41	0.38
2,000,000 – 2,999,999	0.40	0.37
3,000,000 – 3,999,999	0.39	0.36
4,000,000 – 4,999,999	0.39	0.36
5,000,000 – 5,999,999	0.39	0.36
6,000,000 – 6,999,999	0.39	0.36
7,000,000 – 7,999,999	0.39	0.36
8,000,000 – 8,999,999	0.39	0.36
9,000,000 – 9,999,999	0.39	0.35
10,000,000 – 10,999,999	0.39	0.35
11,000,000 – 11,999,999	0.39	0.35
12,000,000 – 12,999,999	0.39	0.35

Appendix B
Tier II

Retrospective Rating
Minimum Premium Percentages
Private Employer – Hazard Group D

Premium Range	$100,000 Claim Limit 150%	$125,000 Claim Limit 150%
25,000 – 29,999	0.78	0.78
30,000 – 34,999	0.75	0.75
35,000 – 39,999	0.72	0.72
40,000 – 44,999	0.70	0.70
45,000 – 49,999	0.68	0.68
50,000 – 54,999	0.66	0.66
55,000 – 59,999	0.65	0.65
60,000 – 64,999	0.63	0.63
65,000 – 69,999	0.62	0.62
70,000 – 74,999	0.61	0.61
75,000 – 79,999	0.60	0.60
80,000 – 84,999	0.59	0.59
85,000 – 89,999	0.58	0.58
90,000 – 94,999	0.58	0.57
95,000 – 99,999	0.57	0.57
100,000 – 112,499	0.56	0.55
112,500 – 124,999	0.54	0.54
125,000 – 137,499	0.53	0.53
137,500 – 149,999	0.52	0.52
150,000 – 162,499	0.51	0.51
162,500 – 174,999	0.50	0.50
175,000 – 187,499	0.50	0.49
187,500 – 199,999	0.49	0.48
200,000 – 224,999	0.48	0.47
225,000 – 249,999	0.47	0.46
250,000 – 299,999	0.46	0.45
300,000 – 349,999	0.45	0.44
350,000 – 399,999	0.44	0.43
400,000 – 499,999	0.43	0.41
500,000 – 999,999	0.41	0.39
1,000,000 – 1,999,999	0.39	0.37
2,000,000 – 2,999,999	0.38	0.36
3,000,000 – 3,999,999	0.38	0.35
4,000,000 – 4,999,999	0.38	0.35
5,000,000 – 5,999,999	0.38	0.35
6,000,000 – 6,999,999	0.38	0.35
7,000,000 – 7,999,999	0.38	0.35
8,000,000 – 8,999,999	0.38	0.35
9,000,000 – 9,999,999	0.38	0.35
10,000,000 – 10,999,999	0.38	0.35
11,000,000 – 11,999,999	0.38	0.35
12,000,000 – 12,999,999	0.38	0.35

Appendix B
Tier II

Retrospective Rating
Minimum Premium Percentages
Public Employer – Taxing Districts

Premium Range	$100,000 Claim Limit 150%	$125,000 Claim Limit 150%
25,000 – 29,999	0.82	0.82
30,000 – 34,999	0.79	0.79
35,000 – 39,999	0.77	0.77
40,000 – 44,999	0.75	0.75
45,000 – 49,999	0.73	0.73
50,000 – 54,999	0.71	0.71
55,000 – 59,999	0.70	0.70
60,000 – 64,999	0.68	0.68
65,000 – 69,999	0.67	0.67
70,000 – 74,999	0.66	0.66
75,000 – 79,999	0.65	0.65
80,000 – 84,999	0.64	0.64
85,000 – 89,999	0.63	0.63
90,000 – 94,999	0.63	0.62
95,000 – 99,999	0.62	0.61
100,000 – 112,499	0.61	0.60
112,500 – 124,999	0.59	0.59
125,000 – 137,499	0.58	0.58
137,500 – 149,999	0.57	0.57
150,000 – 162,499	0.56	0.56
162,500 – 174,999	0.56	0.55
175,000 – 187,499	0.55	0.54
187,500 – 199,999	0.54	0.53
200,000 – 224,999	0.53	0.52
225,000 – 249,999	0.52	0.51
250,000 – 299,999	0.51	0.50
300,000 – 349,999	0.50	0.48
350,000 – 399,999	0.49	0.47
400,000 – 499,999	0.48	0.46
500,000 – 999,999	0.45	0.53
1,000,000 – 1,999,999	0.44	0.40
2,000,000 – 2,999,999	0.43	0.39
3,000,000 – 3,999,999	0.42	0.39
4,000,000 – 4,999,999	0.42	0.38
5,000,000 – 5,999,999	0.42	0.38
6,000,000 – 6,999,999	0.42	0.38
7,000,000 – 7,999,999	0.42	0.38
8,000,000 – 8,999,999	0.42	0.38
9,000,000 – 9,999,999	0.42	0.38
10,000,000 – 10,999,999	0.42	0.38
11,000,000 – 11,999,999	0.42	0.38
12,000,000 – 12,999,999	0.42	0.38

4123-17-56 Safety incentive and safety grant programs.
eff. 07/01/99

A. Pursuant to division (A)(3) of section 4123.29 of the Revised Code, the administrator may grant a discount on premium to an eligible employer who participates in a safety incentive program under this rule.
B. The bureau shall determine whether the employer is eligible for the safety incentive program under this rule. Initially, the bureau will implement a pilot program for the safety incentive program and may limit participation in the program based upon the availability of bureau resources for the program. The safety incentive program is available only to a private state fund employer who satisfies all of the following criteria.
   1. The employer's annual workers' compensation premiums must exceed fifty thousand dollars; and,
   2. The employer's initial experience modifier, that is, the penalty or credit that is applied to the base rate as a result of experience rating, must be greater at the beginning of the program than one hundred and fifty per cent.
C. The division of safety and hygiene of the bureau will contact eligible employers meeting the criteria of paragraph (B) of this rule.
   1. If the employer agrees to participate in the safety incentive program, the owner or chief executive officer of the company shall meet with a bureau safety and hygiene consultant and shall agree that the employer will work to improve its safety performance.
   2. The bureau consultant shall assess the employer's safety and loss control program and review the loss history of the employer. After completion of this assessment, the employer and consultant will work together to develop an action plan to address safety problems and solutions within the workplace. The action plan shall include a process for employee involvement, including any collective bargaining agent, where applicable, in the safety incentive program.
   3. The bureau and employer shall enter into a written agreement detailing the rights, obligations, and expectations of the parties for performance of the safety incentive program.
D. The bureau consultant will meet with the owner or chief executive officer of the employer at least once a month to evaluate the employer's progress.
E. An employer who complies with the requirements of the safety incentive program under this rule shall be eligible to receive a premium rebate as provided for in this rule.
   1. The premium rebate shall be ten per cent.
   2. The premium rebate will be applied to the pure premium, not to administrative assessments, disabled workers' relief fund assessments, or other assessments. The premium rebate will not alter the employer's actual TM calculation under rule 4123-17-03 of the Administrative Code.
   3. The bureau shall determine whether the employer qualifies for the premium rebate based upon the employer's success in meeting the safety objectives of the safety incentive program agreement as provided in paragraph (C)(3) of this rule.
   4. The bureau shall evaluate the employer's safety practices and standards at the inception of the safety incentive program. The bureau shall complete an assessment document determining the employer's facility score prior to implementing the program, and shall provide a copy of the document to the employer with instructions for improvement.
F. Pursuant to section 4121.37 of the Revised Code, the administrator may establish a program of safety grants for education, assistance, and research for eligible employers who participate in the safety grant program under this rule. The safety grant program may include grants to an employer to provide funds for the research and prevention of cumulative trauma disorder injuries and to purchase equipment or conduct training to reduce the number and severity of cumulative trauma disorder injuries.
G. The bureau shall determine whether the employer is eligible for the safety grant program under this rule. The bureau may limit participation in the safety grant program based upon the availability of bureau resources for the program and upon the merits of the employer's proposal. The safety grant program is available only to a private state fund employer or a public employer taxing district that satisfies the following criteria:
   1. The employer shall pay workers' compensation premiums to the state insurance fund and shall have active coverage on the date of agreement to participate in the safety grant program.
   2. For grants to an employer to provide funds for the research and prevention of cumulative trauma disorder injuries, the employer shall submit to the bureau an application to the bureau with its proposal for participation in the safety grant program.
H. The bureau will assess whether the employer is eligible to participate in the safety grant program under this rule.
   1. If the employer requests to participate in the cumulative trauma disorder portion of the safety grant program, the owner or chief executive officer of the company shall meet with a bureau safety and hygiene consultant

if required to review the safety grant program application.

2. The bureau shall assess the employer's safety and loss control proposal and shall review the safety grant program application. If the bureau accepts the employer into the safety grant program, the employer shall conduct a baseline assessment of the worksite and shall conduct a follow-up assessment after the intervention is implemented. The employer shall report the assessment measurements to the bureau. The employer will develop an implementation strategy plan for the safety grant program.
3. The bureau and employer shall enter into a written agreement detailing the rights, obligations, and expectations of the parties for performance of the safety grant program.

I. The bureau may meet with the owner or chief executive officer of the employer to evaluate the employer's progress in the safety grant program. The employer shall provide the bureau access to records or personnel to conduct research into the effectiveness of the safety grant program.

J. An employer who complies with the requirements of the safety grant program under this rule shall be eligible to receive a grant from the bureau as provided in the written agreement.
1. The bureau may establish by written agreement with the employer the maximum amount of the safety grant program grant.
2. The bureau may establish by written agreement with the employer a requirement for matching funds from the employer in a ratio to be determined by the bureau.
3. The bureau shall monitor the employer's use of the safety grant program grant and may recover the entire grant if the bureau determines that the employer has not used the grant for the purposes of the safety grant program or has otherwise violated the written agreement on the safety grant program.

K. The bureau shall evaluate the research data from the safety grant program on a periodic basis. The bureau may publish reports of the research to assist employers in preventing cumulative trauma disorder injuries.

L. The bureau may enter into an agreement with a university in this state to perform research on preventing cumulative trauma disorder injuries.

4123-17-57 Premium for Construction Industry
eff. 01/01/95

A. As used in this rule:
1. As defined in division (F)(3) of section 4123.34 of the Revised Code, "construction industry" includes any activity performed in connection with the erection, alteration, repair, replacement, renovation, installation, or demolition of any building, structure, highway, or bridge. The manual classifications satisfying this definition are listed in paragraph (E) of this rule.
2. "Construction industry employer" is an employer that reports payroll of a construction industry employee for work performed in a construction industry manual classification as defined in paragraph E of this rule.
3. "Construction industry employee" is any employee as defined in division A of section 4123.01 of the Revised Code who performs work and whose payroll is properly reported in a construction industry manual classification as defined in paragraph (E) of this rule.

B. Pursuant to division (F) of section 4123.34 of the Revised Code, the administrator shall determine the premium rates for construction industry employees for payroll paid beginning January 1, 1995, in accordance with the limitations provided in this rule.

C. A construction industry employer shall report the actual remuneration paid to its construction industry employees, except that for payroll paid beginning January 1, 1995, the reportable payroll shall not exceed on a weekly basis an amount as provided in division (F) of section 4123.34 of the Revised Code. This limitation applies only to the construction industry employees of the construction industry employer, and does not apply to employees of a construction industry employer whose payroll is not reported in a construction industry manual classification as defined in paragraph (E) of this rule.

D. The construction industry employer shall maintain records to verify the weekly wages paid to construction industry employees. The payroll limitation for construction industry employees shall apply to weekly payroll, regardless of the hourly or daily remuneration. If upon audit the construction industry employer is unable to document payroll records of an employee on a weekly basis, the bureau shall establish the payroll by the actual remuneration for the payroll reporting period, subject to the maximum limitation as provided in division (F) of section 4123.34 of the Revised Code times the number of weeks in the payroll reporting period.

E. The payroll limitation of this rule shall apply only to the following construction industry manual classifications of a construction industry employer: all of the manual classifications in industry group four, except for manual classification 9009, as provided in the credibility table used for experience rating, Table One, Part B, of rule 4123-17-05 of the Administrative Code. The bureau shall periodically review the manual classifications satisfying the definition of construction industry, and any reclassifications, changes, deletions, or additions to the bureau's

manual classifications or industry groups may result in additions or deletions of manual classifications from this rule.

F. The payroll limitation of this rule shall apply to premium of the construction industry employer for construction industry employees reported under the manual classifications listed in paragraph (E) of this rule. The payroll limitation also applies to the administrative cost and disabled workers' relief fund assessments, and for such purposes the construction industry employer shall report the remuneration of the construction industry employees as provided in paragraph (C) of this rule.

G. For a construction industry employee who is also an officer of a corporation, a sole proprietor, partnership, or member of a family farm corporation, and whose payroll is subject to a payroll limitation by rules 4123-17-07 and 4123-17-30 of the Administrative Code, any additional payroll limitations of this rule also may apply.

H. If upon audit or reclassification of payroll the bureau determines that the payroll of an employee has been improperly classified in a construction industry manual classification and the new or proper manual classification is not a construction industry classification as defined in paragraph (E) of this rule, the bureau shall establish the premium due based upon the full actual remuneration of the employee.

4123-17-58 Drug-free workplace (DFWP) discount program.
eff. 7/1/01

Pursuant to division (E) of section 4123.34 of the Revised Code, the administrator may grant a discount on premium rates to an eligible employer that meets the drug-free workplace (DFWP) program requirements under the provisions of this rule.

A. As used in this rule:

1. "Drug-free workplace program" or "DFWP program" means the bureau's rate program which offers a premium discount to eligible employers for implementing a program addressing workplace use and abuse of alcohol and other drugs, including prescription, over-the-counter, and illegal drug abuse.
2. "Prescription drug abuse" means the use of over-the-counter drugs or medications prescribed by a licensed medical practitioner by someone other than the person for whom they were prescribed or for purposes other than those for which they were prescribed or manufactured.
3. "Accident" means an unplanned, unexpected, or unintended event which occurs on the employer's property, during the conduct of the employer's business, or during working hours, or which involves employer-supplied motor vehicles or motor vehicles used in conducting the employer's business, or within the scope of employment, and which results in any of the following:
   a. A fatality of anyone involved in the accident;
   b. Bodily injury requiring off-site medical attention away from the employer's place of employment;
   c. Vehicular damage in apparent excess of a dollar amount stipulated in the employer's DFWP policy; or
   d. Non-vehicular damage in apparent excess of a dollar amount stipulated in the employer's DFWP policy.

   As used in this rule, "accident" does not have the same meaning as provided in division (C) of section 4123.01 of the Revised Code, and the definition of this rule is not intended to modify the definition of a compensable injury under the workers' compensation law.
4. "Reasonable suspicion" means evidence that an employee is using drugs or alcohol in violation of the company's DFWP policy, drawn from specific, objective facts and reasonable inferences drawn from these facts in light of experience and training. Such facts and inferences may be based on, but are not limited to, any of the following:
   a. Observable phenomena, such as direct observation of drug or alcohol use, possession or distribution, or the physical symptoms of being under the influence of drugs or alcohol, such as but not limited to slurred speech, dilated pupils, odor of alcohol or marijuana, changes in affect, dynamic mood swings, etc.;
   b. A pattern of abnormal conduct, erratic or aberrant behavior, or deteriorating work performance (e.g., frequent absenteeism, excessive tardiness, recurrent accidents) which appears to be related to substance abuse and does not appear to be attributable to other factors;
   c. The identification of an employee as the focus of a criminal investigation into unauthorized drug possession, use, or trafficking;
   d. A report of alcohol or other drug use provided by a reliable and credible source;
   e. Repeated or flagrant violations of the company's safety or work rules, which are determined by a supervisor to pose a substantial risk of physical injury or property damage and which appear to be related to substance abuse or substance use that may violate the employer's DFWP policy, and do not appear attributable to other factors.
5. "Random selection" means drug testing of an employee selected from a pool of employees made regardless

of whether any suspicion of illegal drug use exists. This testing is made without advanced notice to the employee and is based on an equal probability of selection. Random selection testing is based upon an objective and non-discretionary computer program operated and maintained by an outside contractor to identify and test a specified percentage of the total workforce over the course of a year. All employees, including those previously selected for testing, have an equal chance of being selected each time the testing process occurs, such that some employees may be selected more than once for random selection testing while other employees may not be selected at all.

6. "Safety-sensitive position or function" means any job position or work-related function or job task designated as such by the employer, which through the nature of the activity could be detrimental or dangerous to the physical well-being of the employee, co-workers, customers or the general public through a lapse in attention or judgment. The safety-sensitive position or function may include positions or functions where national security or the security of employees, co-workers, customers, or the general public may be seriously jeopardized or compromised through a lapse in attention or judgment.

7. "Supervisor" means an employee who supervises others in the performance of their jobs, has the authority and responsibility to initiate reasonable suspicion testing when it is appropriate, and has the authority to recommend or perform hiring or firing procedures.

8. "Ohio Department of Alcohol and Drug Addiction Services" or "ODADAS" means the state agency an employer may contact to provide technical assistance or referral to available community resources for employers interested in developing a DFWP program. ODADAS shall maintain a list of DFWP developmental consultant programs meeting specified criteria and offering training to assist employers in developing a DFWP program. Such training shall be experience equivalency for purposes of this rule.

9. "Experience equivalency" means consultation and training services offered through a program which facilitates the development of an employer's DFWP program and may qualify the employer to receive a higher discount based on the program level implemented in conjunction with this experience equivalency credit.
   The criteria for a program to be an experience equivalency shall include:
   a. All primary consultants for the organization shall have a minimum of ten hours annual continuing education in drug-free workplace issues;
   b. The organization shall have provided drug-free workplace policy and operational procedures development consultation and training for a period of at least two years; and
   c. For purposes of this rule, the organization shall provide a certificate only to an employer that completes a minimum of fifteen hours of face-to-face consultation and training and a minimum of twenty additional hours developing the employer's drug-free workplace policy and program operations.
10. "Employee assistance plan" means an employer's plan of action and designated appropriate resources to assist employees who:
    a. Seek help on their own for an alcohol or drug problem;
    b. Are referred by management for a possible problem with alcohol or drugs; or
    c. Have a positive alcohol or drug test.
11. "Employee assistance program" or "EAP" means a cost-effective program to assist employees and their families in dealing with problems affecting their work performance. An EAP identifies and helps resolve problems by applying short-term counseling, referral, and follow-up services, as determined by the contractual arrangement with the employer. In addition, the EAP provides such services as management training and consultation; prevention and education programs; crisis intervention; benefits analysis; and organizational development. A qualified EAP is one recognized by industry standards which employs certified personnel and operates in compliance with core-technology specific to the EAP discipline. An "employee assistance program" is to be distinguished from an "employee assistance plan," which is used generically by employers offering a composition of assistance services for employees but which do not adhere to the core technology of the EAP field, as defined by the employee assistance professional association (EAPA).
12. "Drug and alcohol testing" means a range of tests that may be utilized to address employee use or abuse of alcohol and other drugs that affect workplace safety. These tests include pre-employment or new hire testing to screen from the workforce persons with existing substance use or abuse problems that may affect workplace safety; post-accident testing, for employees who may have caused or contributed to an accident due to use or abuse of alcohol or other drugs; reasonable suspicion testing, which utilizes observations from

trained supervisors to identify employees whose behavior suggests use or abuse of alcohol or other drugs that may endanger the employee or other employees; and random drug testing to identify employees who use alcohol or other drugs in contravention of the employer's DFWP policy, with such testing likely to deter substance abuse because employees will not know whether or when they might be tested. The five drugs that are included in the drug testing are amphetamines, cannabinoids (THC), cocaine (including crack), opiates, and phencyclidine (PCP).

13. "Consortia" means an entity established to provide more cost-effective services to employers to help the employers meet the DFWP program requirements. Consortia may involve varied pools of employers and their employees, wherein employer education, supervisor training, and drug and alcohol testing may be offered at a reduced cost to the employers who choose to participate. Consortia for drug and alcohol testing purposes may involve contracts with laboratories certified by the department of health and human services and will operate in concert with established protocols and procedures that are consistent with federal guidelines for testing.
14. "Vendor" means any person or organization that provides service to employers participating in the DFWP program for purposes of employers meeting DFWP program requirements.

B. Application process.

The bureau shall provide application and renewal forms for use in the DFWP program and shall have final authority to approve a state fund employer to receive a discount based on its participation in this program. An employer's participation in a DFWP program shall be on a program year basis, as shall renewal of participation in a DFWP program. Only state fund employers requesting consideration for the DFWP program discount should submit an application. The bureau shall evaluate each application to determine the employer's eligibility to receive a discount under the DFWP program, the employer's eligibility for a specific program level, and the applicable discount per cent.

1. A private employer may apply either by June thirtieth for the program year beginning July first of that year to June thirtieth of the following year, or by December thirty-first for the program year beginning January first of the following year to December thirty-first of that year. The progress report and renewal deadlines are March thirty-first for a program year that begins on July first, and September thirtieth for a program year that begins on January first.
2. A public employer taxing district may apply by December thirty-first prior to the program year beginning January first of the following year to December thirty-first of that year. The progress report and renewal deadlines are September thirtieth for a program year beginning January first.
3. An employer may withdraw its application for enrollment in the DFWP program under this rule at any time prior to receiving the discount on its premium. When an employer becomes aware that it is unable to meet the program requirements associated with its approved DFWP program level by the required implementation date, the employer shall notify the bureau of its inability and shall withdraw from the program. The employer shall return any monetary benefits associated with any discount received, including interest, which shall be calculated as provided in division (E) of section 4123.41 of the Revised Code.

(C) Eligibility requirements.

The DFWP program under this rule is available in the form of technical assistance and support to all private and public employers. However, eligibility for the discount is limited to state fund employers, with the per cent of discount based on an employer's participation in one or more alternate rating programs. A state fund employer seeking a discount shall apply on a bureau application form to implement a DFWP program and shall satisfy all of the eligibility requirements of this rule. The bureau shall review the application to determine whether the employer is eligible to receive a discount for participation in the DFWP program, determine whether the employer is eligible for the level of program applied for, and determine and approve the discount percentage for the level of program for which the employer is determined to be eligible. An employer that is found to be ineligible for participation in the DFWP program may reapply in a subsequent program year. It is recognized that an employer may implement a DFWP program that exceeds the minimum requirements for the discount level approved by the bureau. For all levels of a DFWP program, the employer shall meet the following requirements:

1. If an employer participates in any other alternate rating program offered by the bureau, or receives a discount, credit, or benefit for participation in group rating, retrospective rating, or the premium discount program in the same policy year as the DFWP program, the employer may participate in the DFWP program and may receive the discount provided for under this rule. The employer may receive only the maximum discount, credit, or benefit for whichever program amount is greater for the given policy or program year, or as specifically defined below, as follows:
   a. An employer participating in both the premium discount program plus under rule 4123-17-70 of the Administrative Code and the DFWP program may receive a premium discount equal to the greater of the

premium discount program discount or the DFWP program discount as earned individually for the given policy or program year.

(i) Notwithstanding the provision of paragraph (C)(1)(a) of this rule, during calendar year 2002, an employer participating in both the premium discound program plus under rule 4123-17-70 of the Administrative Code and DFWP program under this rule may receive a premium discount for both programs. The discounts shall apply so long as the employer satisfies the requirements of each of the programs.

(ii) In applying the discounts for the two programs, the bureau shall first apply the PDP plus discount to the extent allowable under paragraph (I) of rule 4123-17-70 of the Administrative Code, and then the DFWP discount allowable under this rule.

(iii) The bureau shall implement the provisions of paragraphs (C)(1)(a)(i) and (C)(1)(a)(ii) of this rule during calendar year 2002 only. The bureau shall study the effectiveness of the program and report the results to the workers' compensation oversight commission by March 1, 2003, together with a recommendation whether to continue to permit an employer to receive the discounts for implementing both programs.

b. An individual employer participating in both group rating under rules 4123-17-61 to 4123-17-68 of the Administrative Code and the DFWP program may implement the DFWP program and receive the associated premium discounts in addition to the group discount; provided, however, the combined discounts may not exceed the maximum discount allowed under the group rating plan.

c. An employer participating in both retrospective rating under rules 4123-17-41 to 4123-17-54 of the Administrative Code and the DFWP program may only receive a premium discount equal to the maximum of either the discount under the DFWP program or the difference between the employer's premium calculated as an individual employer and calculated in the retrospective rating program.

d. An employer that has an existing substance-free program that has been in place for four or more years at the time of application and is evaluated as comparable to the level one program under this rule is not eligible for a discount under this rule.

e. An employer not eligible for a discount under this rule may implement a DFWP program and is encouraged to do so. The bureau and ODADAS will identify available resources for support and technical assistance.

2. The employer shall be current as of March thirty-first for the application year beginning July first, or September thirtieth for the application year beginning January first, and subsequent renewal years (not more than forty-five days past due) on any and all premiums, assessments, penalties or monies otherwise due to any fund administered by the bureau, including amounts due for retrospective rating at the time of the application deadline.

3. The employer cannot have cumulative lapses in workers' compensation coverage in excess of fifty-nine days within the eighteen months preceding the application or renewal deadline.

4. The employer shall be in an active or reinstated policy status the first day of the policy year for the DFWP program.

5. An employer in the DFWP program shall continue to meet all eligibility requirements during the year of participation in the program, when applying for renewal, and during each subsequent year of participation in the program, regardless of the level of the employer's DFWP program.

D. General program requirements.

In signing the application form, the chief executive officer or designated management representative of the employer shall certify that the employer shall meet, at a minimum, the program requirements associated with the level DFWP program for which the employer has applied. This certification is required for the employer to be considered for the discount associated with implementing the specific level DFWP program, and the signature certifies that the employer shall return any monetary benefits associated with any discount received, including interest, based on failure to implement or meet the DFWP program level requirements for which it has applied and been approved.

1. An employer approved by the bureau for a DFWP program that does not have an existing substance-free workplace program at the time of application or that has a program in place for less than one year, may receive a maximum of five years of discount under this rule.

2. An employer that has an existing substance-free workplace program at the time of application for at least one year but less than four years that is evaluated as comparable to the level one program under this rule may receive a maximum of four years of discount under this rule.

E. Program requirements - all program levels.

To receive a discount for implementing and operating a DFWP program, an employer shall fully implement, at a minimum, the following program components by the applicable dates.

1. Policy - The DFWP program shall include a written policy statement, which, at a minimum, shall consist of the following:
   a. Articulate all the elements of the level DFWP program, which the employer is implementing;
   b. State management's incentive for creating a substance-free workplace (e.g., concern for employee safety and health, productivity, accident prevention, and loss control);
   c. Identify a DFWP program administrator and indicate the person's role or responsibilities with regard to the DFWP program;
   d. Communicate the DFWP program and policy through initial presentation to all employees prior to the program implementation and/or on a repetitive basis annually through employee education sessions;
   e. Clearly state that the program applies to all employees, including all levels of management;
   f. Contain appropriate references to collective bargaining agreements and show how the DFWP program works in concert with these agreements to promote a safer workplace for all employees;
   g. Address the use or abuse of alcohol, prescription medications, over-the-counter medications, or illegal drugs. The policy should include which drug or alcohol tests will be used, at what cutoff levels and what testing procedures and protocols will be applied; and a clear statement that supervisors will be trained regarding their responsibilities related to various testing prior to the implementation of any testing;
   h. Include a commitment to rehabilitation;
   i. Describe how referrals may be made for testing, assessment, and employee assistance;
   j. Be in compliance with all federal and state laws or regulations;
   k. State what is prohibited and the consequences for employees of a violation of this policy;
   l. State the consequences, if any, for an employee's refusal to submit to a medical examination or a drug or alcohol test in conjunction with the operation of the employer's DFWP program;
   m. State the consequences for any employee attempting to adulterate a specimen or otherwise manipulate the drug or alcohol testing process;
   n. State that law enforcement authorities may be contacted and requested to come onto the employer's property when appropriate in conjunction with a referral for criminal prosecution;
   o. Contain a statement that nothing in the policy alters the employment-at-will status as it affects any other employment issues with the employer;
   p. State that an employee's violation under the DFWP policy shall not be reported to law enforcement officials unless required by a regulatory body or by criminal law provisions; and
   q. Include a discussion of confidentiality of the program records to ensure the privacy rights of individuals.
2. Employee education - The DFWP program shall include employee education, which, at a minimum, shall consist of the following:
   a. A total of at least two hours annually for all current employees prior to implementation of the DFWP program, and at least annually thereafter for each program year in which the employer operates a DFWP program, and with at least one hour for all new employees within the employee's first four weeks of employment;
   b. Inform employees about the content of the DFWP program as delineated in the written policy, a copy of which will be presented, discussed and acknowledged by each employee's signature on an appropriate form;
   c. Stress management's commitment to the program;
   d. Include the disease model for alcohol and other drugs, the signs and symptoms associated with substance use and abuse, and the effects and dangers of commonly used drugs in the workplace;
   e. Share a list of helping resources in the community for employees to utilize for themselves or their families; and
   f. Be presented by a qualified educator or a presenter supervised by a qualified educator holding one of the following credentials:
      (i) Substance abuse professional (SAP);
      (ii) Certified employee assistance professional (CEAP);
      (iii) Certified chemical dependency counselor (CCDCIII);
      (iv) Ohio certified prevention specialist 1 (OCPS 1); or
      (v) Ohio certified prevention specialist 2 (OCPS 2).
3. Supervisor training - The DFWP program shall include supervisor training, which, at a minimum, shall consist of the following:
   a. At least four hours of initial training for all current and new supervisors (with at least two hours of training within six weeks of a current employee becoming a supervisor or from the date of hire of a supervisor), in addition to the annual two hours of employee education, for a total of six hours annually;

b. In subsequent program years, a minimum of two hours of refresher training for supervisors who have received the initial four hours of training, which is in addition to the annual two hours of employee education, for a total of four hours;
c. A discussion of a supervisor's responsibilities in relationship to the employer's DFWP program, including but not limited to how to recognize a possible alcohol or other drug problem; how to document behaviors that demonstrate an alcohol or other drug problem; how to confront employees with the problem in terms of their observed behaviors; how to initiate reasonable suspicion testing; how to make an appropriate referral for assistance; how to follow up with employees re-entering the work setting after a positive drug test; and how to handle DFWP program responsibilities in a manner that is consistent with any pertinent collective bargaining agreements; and
d. Be presented by a qualified trainer or a presenter supervised by a qualified trainer holding one of the credentials provided in paragraphs (E)(2)(f)(i) to (E)(2)(f)(v) of this rule.

4. Drug and alcohol testing - The DFWP program shall include drug and alcohol testing which, at a minimum, shall consist of a five-panel drug screen with gas chromatography/mass spectrometry (GC/MS) and alcohol testing consistent with federal standards. The employer shall implement and pay for drug and alcohol testing as follows, with the stipulation that all categories of testing shall be clearly described and defined in the employer's written policy.
   a. Pre-employment/new-hire testing: at one hundred per cent (drug test required), with testing to be conducted before or within the first ninety days of employment;
   b. Post-accident: All employees who may have caused or contributed to an on-the-job accident, as defined in paragraph (A)(3) of this rule, shall submit to a drug or alcohol test. This test will be administered as soon as possible after necessary medical attention is received, or within eight hours for alcohol and within thirty-two hours for other drugs.
   c. Reasonable suspicion testing based on documentation and concurrence among the trained observing supervisor and a second trained supervisor, wherever possible.
   d. Follow-up testing, for any employee with a positive test, commencing with a return-to-duty test as the first in a minimum of four tests over the period of a year from the date of return to duty for such employee where the employer brings the employee back to work or returns the employee to a safety-sensitive position or function after a positive test; no set maximum during the first year that begins with the date of return to duty. A maximum number of tests after the first year from date of return to work are to be determined by agreement between the employee, the substance abuse professional assessing or treating the employee, and the employer.

   For the purposes of the DFWP program, the forms of testing to be utilized will be urinalysis (EMIT screen, also referred to as a drug screen, plus GC/MS confirmation) for a panel of five drugs, and breath or saliva with a confirmatory evidential breath test (EBT) for alcohol. However, if an EBT is not available or reasonably accessible, a blood test should be made available to the employee to determine the presence of alcohol. The employer is required to document and maintain on file the reason the EBT was not administered. To ensure the integrity of testing and for the safety of employees, participating companies must adopt the procedures and chain-of-custody guidelines recommended by the federal department of health and human services (DHHS) and required by the federal department of transportation. Employers shall ensure that DHHS certified laboratories process the test results, and that a qualified medical review officer is responsible for evaluating all test results.

   Supervisors shall receive training regarding their responsibilities related to various testing prior to implementation of testing. Cut-off levels shall be clearly stated in the written policy, along with the procedures or protocols, such as chain of custody, that define the testing process.

5. Employee assistance - The DFWP program shall include an employee assistance plan as defined in paragraph (A)(10) of this rule for levels 1 and 2 DFWP programs, or an EAP as defined in paragraph (A)(11) of this rule for a level 3 DFWP program. Upon an employee's positive test, in addition to any corrective action deemed appropriate, the employer shall explain to the employee what a substance abuse assessment is and, by way of referral, shall provide a list containing names and addresses of qualified substance abuse assessment resources who can administer an assessment.

   The specifics of the employee assistance plan as well as any requirements for which the employer contracts with a provider are dependent upon the level DFWP program which the employer implements.

6. Other - The DFWP program may contain other provisions related to specific program requirements that do not fall into one of the five basic program components.

7. An employer may use a vendor for any of the following: to develop its DFWP program policy under paragraph (E)(1) of this rule; for an educator or presenter supervised by an educator for employee education under paragraph (E)(2) of this rule; for a trainer or presenter supervised by an educator for supervisor training under

paragraph (E)(3) of this rule; for drug and alcohol testing under paragraph (E)(4) of this rule; or for employee assistance under paragraph (E)(5) of this rule.

a. For an employer to use the services of a vendor under this rule, the vendor, if required by law to possess workers' compensation coverage, either:
   (i) Shall be a current participant in the bureau's DFWP program under this rule;
   (ii) Shall have completed all of the vendor's years of eligible discount in the DFWP program and shall still maintain a DFWP program comparable to the DFWP program under this rule; or
   (iii) If the vendor has applied to the DFWP program under this rule but the bureau has determined the vendor to be ineligible for the program based upon the provisions of paragraph (C)(1)(e) of this rule, shall develop and maintain a DFWP program comparable to the DFWP program under this rule.

b. If the vendor has applied to the DFWP program under this rule but the bureau has determined the vendor to be ineligible for the program based upon any of the provisions of paragraphs (C)(2), (C)(3), or (C)(4) of this rule, the employer may not use the vendor in the DFWP program to develop its DFWP program or meet any of the DFWP program requirements under this rule.

8. The bureau may establish and administer consortia for the purpose of more effective program administration and reduced costs for employers participating in the DFWP program under this rule. Consortia will allow the bureau to develop pools to offer groups of employers and their employees the employee awareness information for the employer education requirement of paragraph (E)(2) of this rule, the skill building training requirement of paragraph (E)(3) of this rule, and to pool random testing and other drug and alcohol testing services for the drug testing requirements of paragraph (E)(4) of this rule. The bureau will develop the criteria that will govern how the consortia will operate.

F. Additional level-specific program requirements.

In addition to the general requirements of paragraph (E) of this rule applicable to all employers participating in the DFWP program and receiving a discount, this paragraph of this rule describes additional specific program requirements for the various levels of the DFWP program.

1. Level 1 DFWP program.

   To receive a discount for a level 1 DFWP program, an employer shall meet all of the general requirements of paragraph (E) of this rule.

2. Level 2 DFWP program.

   To receive a discount for a level 2 DFWP program, an employer shall apply for level 2 DFWP program and, after the first full program year, shall have had a level 1 DFWP program in place for at least one year, shall demonstrate to the satisfaction of the bureau proficiency and readiness to implement a level 2 DFWP program through a documented safety program that is already in place, or shall either have an existing comparable level 1 substance-free workplace program in place, or demonstrate its proficiency and readiness to implement a level 2 DFWP program through documented experience equivalency from a program offering employer DFWP development training that has met the criteria specified in paragraph (A)(9) of this rule and is on the list maintained by ODADAS, or shall be a participant in a consortium that meets the requirements established by the bureau pursuant to paragraph (A)(13) of this rule. The employer shall fully implement the program components detailed in paragraph (E) of this rule, and in addition shall implement the following:

   a. In addition to the drug and alcohol testing DFWP program requirements of paragraph (E)(4) of this rule, the employer shall include random drug testing of ten per cent of the employer's workforce each program year, as shall be clearly described and defined in the employer's DFWP policy. For public employers, random drug testing applies only to safety-sensitive positions or functions, as defined by the employer in the DFWP policy and paragraph (A)(5) of this rule.

   b. In addition to the employee assistance plan DFWP program requirements of paragraph (E)(5) of this rule, the employer shall have pre-established a relationship for assessment which allows for a three-way exchange of information, with the appropriate consent, among the employee, employer, and provider. A first positive drug or alcohol finding shall result in a direct referral for assessment rather than just providing a list of names and addresses of qualified substance abuse assessment resources, unless otherwise defined within the DFWP policy for specific employment positions. In addition, the employer shall identify in the policy who will pay for the services associated with an assessment.

   c. The employer shall implement the first five steps of the bureau's ten step business plan under rule 4123-17-70 of the Administrative Code during the first program year in which it operates a level 2 DFWP program.

3. Level 3 DFWP program.

   To receive a discount for a level 3 DFWP program, an employer shall apply to implement a level 3 DFWP program; shall have conducted a DFWP program at level 1, 2, or 3 for two full years, and shall have met the renewal requirements. The employer shall fully implement the program components detailed in paragraph

(E) of this rule, and in addition shall implement the following:

a. In addition to the drug and alcohol testing DFWP program requirements of paragraph (E)(4) of this rule, the employer shall include random drug testing of twenty-five per cent of the employer's entire workforce each program year. For public employers, random drug testing applies only to safety-sensitive positions or functions, as defined by the employer in the DFWP policy and paragraph (A)(5) of this rule.

b. In addition to the employee assistance plan DFWP requirements of paragraphs (E)(5) and (F)(2)(b) of this rule, the employer shall offer employees health care coverage which includes chemical dependency counseling and treatment services.

c. At level 3, the employer shall implement all ten steps of the bureau's ten step business plan under rule 4123-17-70 of the Administrative Code.

G. Progress reporting and renewal requirements.

If the bureau determines that an employer is eligible to implement a DFWP program, the employer shall comply with the following requirements for initial participation, and renewal of annual participation in the DFWP program. In order to qualify for renewal, an employer shall have implemented all of the program requirements associated with the DFWP program level for which a discount was obtained by the appropriate implementation date.

1. The employer shall permit the bureau or its designee access to the employer's job sites for on-site audit of the employer's DFWP program components, related records and documentation. The employer shall sign a "release of information form" for compliance monitoring and cost-benefit analysis purposes which authorizes the bureau to have access to various aggregate information from drug testing laboratories, medical review officers and the employee assistance plan or employee assistance program.

2. By the end of the first quarter of the program year or a subsequent date established by the bureau, for the first year of an employer's DFWP program, the chief executive officer or designated management representative of the employer shall certify on a form provided by the bureau a statement that the employer has fully implemented and is operating its DFWP program in accordance with the program level requirements for which the employer has applied or is receiving the discount.

3. The employer shall submit to the bureau a DFWP program progress report on a form provided by the bureau providing information regarding its DFWP program for the program year. The progress report shall include information related to drug and alcohol testing and may also include additional information related to other DFWP program components as requested on the progress form. If the employer is applying for renewal, the employer shall include the DFWP program level that is requested for the next year. The reports shall be certified by the chief executive officer or designated management representative of the employer.

   a. Policy - The employer shall certify that it has developed a DFWP policy that meets or exceeds the program requirements associated with the level of DFWP program for which the employer is receiving a discount. The employer shall submit a copy of the written policy with the certification form. The employer shall maintain the following information on site for audit purposes:
      (i) A copy of the written policy; and
      (ii) Copies of signed acknowledgments from all employees regarding receipt of a copy of the employer's DFWP program policy.

   b. Employee education - The employer shall maintain on site statistics regarding the number of employees educated under the DFWP program, the names and qualifications of all educators who presented the DFWP program employee education sessions, and the names and qualifications of persons supervising any of these educators. In addition, the employer shall maintain the following information on site for audit purposes:
      Original attendance sheets, signed by each employee who attended DFWP program employee education, indicating the date and number of hours of each session.

   c. Supervisor training - The employer shall maintain on site statistics regarding the number of supervisors trained under the DFWP program, the names and qualifications of all trainers who presented the DFWP program supervisor training, and the names and qualifications of persons supervising any of these trainers. In addition, the employer shall maintain the following information on site for audit purposes:
      Original attendance sheets, signed by each supervisor who attended DFWP program supervisor training, indicating the date and number of hours of each session.

   d. Drug and alcohol testing - The employer shall report statistics regarding the number of employees tested under the employer's DFWP program. The employer shall maintain on site for audit purposes copies of all billings from medical review officers and laboratories. The following statistics shall be reported:
      (i) Total number of employees employed by the company;
      (ii) Number of safety-sensitive positions or functions for both private employers and public employers;
      (iii) Program year and dates or periods of time in which the testing occurred;
      (iv) Number of new hires and percentage tested;

*(Note: The C-63 form is a computer generated form. BWC sends this form to the employer only when additional information is necessary to process a claim.)

(v) Aggregate reporting of the number of employees tested for each category of testing required in the employer's DFWP program, including the number and per cent of employees tested for pre-employment/new hire, reasonable suspicion, post-accident, government required, random (if applicable), and other testing if applicable; number of positive versus negative tests for each category; and

(vi) Names of medical review officers and names, addresses, phone numbers, and contact persons for all labs or collectors utilized by the employer for drug and alcohol testing under the DFWP program.

e. Employee assistance - The employer shall maintain on site the following information regarding its employee assistance plan or EAP under the DFWP program:
The name of the organization that provided the employee assistance services, and the name and telephone number of the contact person.

f. Other - An employer implementing a level 2 DFWP program shall report its progress in implementing the first five steps of the bureau's ten step business plan, and an employer implementing a level 3 DFWP program shall report its progress in implementing all ten steps of the ten step business plan. An employer implementing a level 2 or level 3 DFWP program shall maintain records on site of its implementation of either the first five steps or all ten steps of the bureau's ten step business plan, as applicable.

H. Disqualification from program and reapplication.
The bureau may cancel an employer's participation in the DFWP program for the employer's failure to fully implement a DFWP program in compliance with the approved program level. The bureau shall send written notice of cancellation to the employer, and shall require the employer to reimburse the bureau for any discounts received inappropriately, plus interest, as provided in paragraphs (B)(3) and (D) of this rule.

1. If the bureau cancels an employer from the DFWP program under this rule for failure to meet the program requirements, the employer may reapply for the DFWP program for the next program period, unless the employer has received a discount and has failed to reimburse the bureau for the discount plus interest. The bureau may deny the application based on circumstances of the initial program period.
2. When an employer becomes aware that it is unable to fully implement its DFWP program by the required implementation date, the employer shall notify the bureau immediately. The employer's failure to notify the bureau of its inability to fully implement the DFWP program may disqualify the employer from re-applying for the program in the future, even after the required repayment of any discount that may have been received.

I. Discount requirements.
An employer participating in the DFWP program or meeting renewal performance standards under this rule shall be eligible to receive discounts as provided for in this rule.

1. The discount for an employer implementing a DFWP program shall be as follows:
   a. For an employer implementing a level 1 DFWP program, ten per cent;
   b. For an employer implementing a level 2 DFWP program, fifteen per cent;
   c. For an employer that has operated a DFWP program at level 1, level 2 or level 3 (the latter without a level 3 discount) for a total of no less than two full years; upon implementing a level 3 DFWP program, the employer is eligible for twenty per cent for each year of remaining eligibility in which the employer is approved to participate at a level 3 DFWP program.
2. The discount will be applied to the employer's premium rate, but not to the disabled workers' relief fund assessments, or other assessments. The discount will not alter the employer's actual total modification calculation under rule 4123-17-03 of the Administrative Code.
3. The application of the discount associated with the level of the DFWP program approved by the bureau for each employer shall occur effective July first or January first of the appropriate program year for private employers, and January first of the appropriate program year for public employers.
4. An employer is limited to four continuous years, if eligible for four years of discount, or five continuous years, if eligible for five years of discount, to complete its maximum participation in the discount program under this rule; except that an employer which drops out of the DFWP program without receiving a discount or which repays any discount that was received, plus interest, may be considered for four or five years of discount, based on eligibility.
5. An employer which has completed its eligible four years or five years of participation in the DFWP program under this rule is ineligible to reapply.

J. An employer may appeal enrollment rejection and renewal rejection to the bureau's adjudicating committee pursuant to rule 4123-14-06 of the Administrative Code.

K. Hold harmless statement.
Nothing in this rule requires an employer to implement any policies or practices in developing a DFWP program that conflict or interfere with existing collective bargaining agreements. Rather, the bureau suggests that the

employer and employees engage in a collaborative effort to be successful in improving workplace safety by implementing a DFWP program that includes employee input and support.

Where there are legal issues related to development and implementation of a DFWP program, it is the employer's responsibility to consult with its legal counsel to resolve these issues. An employer shall certify in its application to the bureau that it shall hold the state of Ohio harmless for responsibility or liability under the DFWP program.

L. Pursuant to section 4121.37 of the Revised Code, the administrator may establish a program of safety grants for education, assistance, and research for eligible employers who participate in the safety grant program. The safety grant program may include grants to an employer participating in the drug-free workplace discount program under this rule or to an employer with a program comparable to the DFWP program under this rule for the employer to provide for employee and supervisor education and training as required under paragraphs (E)(2) and (E)(3) of this rule.

The administrator or administrator's designee may authorize special safety grants which will be given in furtherance of drug-free workplace efforts to those employers who demonstrate capability of promoting the development of any drug-free workplace program component on a regional, statewide or industry-specific level including, but not limited to, incorporation of labor efforts to promote education, training and testing.

1. The bureau shall determine whether the employer is eligible for the safety grant program grants under this rule. The bureau may limit participation in the safety grant program based upon the availability of bureau resources for the program and upon the merits of the employer's proposal. The safety grant program is available only to a private state fund employer or a public employer taxing district that shall pay workers' compensation premiums to the state insurance fund, shall have active coverage on the date of agreement to participate in the safety grant program, and shall be a participant in the drug-free workplace discount program under this rule or an employer with a program comparable to the DFWP program under this rule at the time of application for the safety grant program.
2. The bureau will assess whether the employer is eligible to receive a safety grant under this rule. The bureau and employer shall enter into a written agreement detailing the rights, obligations, and expectations of the parties for performance of the safety grant program.
3. The bureau may meet with the owner or chief executive officer of the employer to evaluate the employer's progress in the safety grant program. The employer shall provide the bureau access to records or personnel to conduct research into the effectiveness of the safety grant program.
4. An employer who complies with the requirements of the safety grant program under this rule shall be eligible to receive a grant from the bureau as provided in the written agreement.
   a. The bureau may establish by written agreement with the employer the maximum amount of the safety grant program grant.
   b. The bureau may establish by written agreement with the employer a requirement for matching funds from the employer in a ratio to be determined by the bureau.
   c. The bureau shall monitor the employer's use of the safety grant program grant and may recover the entire grant if the bureau determines that the employer has not used the grant for the purposes of the safety grant program or has otherwise violated the written agreement on the safety grant program.
5. The bureau shall evaluate the research data from the safety grant program on a periodic basis. The bureau may publish reports of the research to assist employers in maintaining a drug-free workplace.

4123-17-59 Thousand Dollar Medical-Only Program
eff. 03/01/95

A. Any employer who is paying premiums to the state insurance fund and whose coverage is in force may elect to participate in the thousand dollar medical-only program as provided in section 4123.29 of the Revised Code. No formal application is required; however, an employer must elect to participate by telephoning the bureau after July 1, 1995. Once an employer has elected to participate in the program, the employer will be responsible for all bills in all medical-only claims with a date of injury the same or later than the election date, unless the employer notifies the bureau within fourteen days of receipt of the notification of a claim being filed that it does not wish to pay the bills in that claim, or the employer notifies the bureau that the one thousand dollar maximum has been paid, or the employer notifies the bureau of the last day of service on which it will be responsible for the bills in a particular medical-only claim.

B. Employers may pay bills on any alleged medical-only injury. Payment of a bill by an employer does not waive the bureau's right to adjudicate the claim, nor does it waive the employer's right to contest the claim should a claim be filed.

C. This program in no way supersedes the right of any injured worker to file a workers' compensation claim with the bureau.

D. An employer or its agent may elect to pay to the claimant or on behalf of the claimant the first one thousand dollars of a filed compensable medical-only claim. Employers may elect which medical-only claims they do not wish to cover under this program.
   1. An employer electing to pay bills in its employees' medical-only claims is responsible for all bills in a claim until the one thousand dollar maximum is reached and the employer provides notice to the bureau that the employer has paid the first one thousand dollars of the bills in the claim by providing the bureau the date of service of the bill which reached the one thousand dollar maximum, or the employer provides notice to the bureau that it no longer wishes to be responsible for the bills in a particular claim by providing the bureau the last date of service that it will pay. The bureau will process all related bills received with a date of service later than that date. The employer will be responsible for all bills from the date of injury until that date of service.
   2. If the thousand dollar maximum has not been reached and the payment of a bill will exceed the one thousand dollar maximum, the employer should pay that portion of the bill that will bring the payment to the one thousand dollar maximum and inform the provider to bill the bureau for the remainder of the bill. The employer should then notify the bureau that the first one thousand dollars has been paid, and provide proof of such payment and copies of all bills paid, in the proper billing format, to the bureau. The bureau will then be responsible for processing all future bills.
   3. The employer cannot elect to pay only certain bills for a claim and submit other bills in that claim to the bureau for payment; once the employer notifies the bureau for the bureau to pay the bills, the bureau will process all the related bills in that claim after the date of service indicated by the employer.
   4. Once an employer has elected to pay medical-only claims under this program, the employer must pay all bills under this program within thirty days of receipt of the bill. The employer shall provide copies of the bills paid in the claim, in the proper billing format, to the bureau and the injured worker or their representative upon request.

E. An employer electing this program must keep a record of the injury to include: name, address and social security number of the injured worker; date and time of injury; type of injury; part of body injured; and a brief description of the accident or occurrence. The employer also shall keep a copy of all bills with proof and date of payment under this program. This information will be made available to the bureau and the injured worker or their representative upon request. The information must be kept on file for six years from the last date a bill has been paid by the employer or the information has been received by the bureau.
   1. An employer in the program must notify the bureau on the medical-only claim application C-3, the additional information request form C-63*, or by telephone of its intention not to cover the first one thousand dollars of the medical costs of the claim. This notification must be received by the bureau within fourteen days of the employer's notification that a claim has been filed.
   2. The bureau will process all related bills in a filed medical-only claim in the normal manner unless the employer has previously notified the bureau that it has elected to participate in the one thousand dollar program.
   3. In those cases in which the bureau has been properly notified by the employer of the employer's intention to directly pay the bills, the bureau shall not pay any bills submitted to the bureau directly from the provider but will notify the provider that the bill should be submitted to the employer until the provider is notified by the employer that the bureau is responsible for the bills in the claim. No interest shall be paid by the bureau on account of bills not paid within thirty days if such bills are the responsibility of the employer.
   4. All bills submitted to the bureau or the employer for payment must be in the proper billing format and must be received by the bureau or the employer within two years of the last date of service on the bill.

F. An employer electing this program has the responsibility to notify the injured worker and medical provider, in writing, of the acknowledgment of the alleged medical-only injury, that it has elected under section 4123.29 of the Revised Code to pay the first one thousand dollars, that all bills should be submitted to the employer, and that the injured worker and the bureau should not be billed.
   1. Once an employer in this program pays a bill on a work-related injury the bureau will not reimburse that employer.
   2. In the event that duplicate payment is made, it will be the employer's responsibility to seek reimbursement from the provider. The employer may request reimbursement of such bills from the provider, and the provider shall reimburse the employer where the bureau has paid the bill.
   3. In the event that a medical-only claim changes to a lost time claim, the bureau will not reimburse the employer for bills that have been paid by the employer under this program.

G. The employer shall pay all bills as billed or agree upon an appropriate reimbursement level with the provider. The bureau will not assist the employer in determining the fee payable; however, the bureau UCR fee schedule and other fee maxima programs used by the bureau will be made available for the use of the employer. Providers must bill the employer using the proper bureau format and their usual and customary fee. Providers may not balance bill the injured worker. Providers may only balance bill the bureau on the occasion of a bill that would

require an employer to exceed the one thousand dollar maximum. The bureau will not mediate fee disputes between the employer and the provider.

H. Payments made by the employer in this program will not be charged to that employer's experience modification; however, if a claim has been filed with the bureau and bills paid by the bureau, these payments will be included in the employer's experience modification. The bureau will not adjust the employer's experience modification to remove such payments unless the employer has complied with this rule and the bureau has made such payments in contravention of this rule. Failure by an employer to make timely payments on all bills will not affect the coverage of that employer and will not obligate the bureau to pay interest to the medical provider; however, the bureau may exclude employers who do not make timely payment on all bills in this program from participation in this program. An employer may appeal a decision of the bureau excluding the employer from this program to the adjudicating committee under rule 4123-14-06 of the Administrative Code.

I. An employer who elects to participate in this program may cancel its participation in the program at any time by telephoning the bureau. The bureau will process all related bills in all medical-only claims against that employer's account with an injury date the same as the date of the telephone call or later.

4123-17-61 Criteria for group experience rating

eff. 7/1/01

A. The administrator shall offer a plan that groups employers for rating purposes. Employers shall retain their separate risk identity, but shall be pooled and grouped for rating purposes only, specifically with respect to experience rating.

B. In establishing a group for group rating purposes, the sponsoring group organization or individual employers in the group must satisfy all of the following requirements:

1. All of the employers within the group must be members of the sponsoring organization. The sponsoring organization must have been in existence for at least two years prior to the last date upon which the group's application for coverage may be filed with the bureau of workers' compensation as provided in rule 4123-17-62 of the Administrative Code.
2. The organization must be formed for a purpose other than that of obtaining group workers' compensation coverage. The bureau shall require the organization to document its purpose by its charter, by-laws, or other evidence. So long as all of the other criteria of this rule are satisfied, a parent corporation may be a sponsoring organization and, if it qualifies under the criteria of this rule, a member of a group of its subsidiary corporations for group rating purposes.
3. The employers' business in the organization must be substantially similar such that the risks which are grouped are substantially homogeneous. A group shall be considered substantially homogeneous if the main operating manuals of the risks as determined by the premium obligations for the rating year beginning two years prior to the coverage period are assigned to the same or similar industry groups. Industry groups are determined by appendix B of rule 4123-17-05 of the Administrative Code. Industry groups seven and nine as well as eight and nine are considered similar. A sponsoring organization may sponsor more than one group.
4. The group of employers must consist of at least one hundred individual risk members or a group where the aggregate workers' compensation premiums of the members are, as determined by the administrator, expected to exceed one hundred fifty thousand dollars during the coverage period. For public employer taxing districts, the coverage period shall be January 1 through December 31 of a year. For private employers, the coverage period shall be July 1 through June 30 of the following year.
5. The formation and operation of the group program in the organization must substantially improve accident prevention and claims handling for the employers in the group. The bureau shall require the group to document its plan or program for these purposes, and, for groups reapplying annually for group coverage, the results of prior programs.
6. Each employer seeking to enroll in a group for workers' compensation coverage must have active workers' compensation coverage according to the following standards:
   a. Unless the employer submits prior to the application deadline a dispute of the obligation to the bureau's adjudicating committee by a written letter containing the detailed reasons for the objection and the supporting documentation, the employer must be current (not more than forty-five days past due) on any and all premiums, administrative costs, assessments, fines or monies otherwise due to any fund administered by the Ohio bureau of workers' compensation, including amounts due for retrospective rating, at the time of the application deadline date as defined in rule 4123-17-62(B) of the Administrative Code;

b. As of the deadline for the application for group rating, the employer must be current on the payment schedule of any part-pay agreement into which it has entered for payment of premiums or assessment obligations;
c. The employer cannot have cumulative lapses in workers' compensation coverage in excess of fifty-nine days within the eighteen months preceding the application deadline date for group rating. However, the cumulative lapse period under this section that was used to disqualify an employer from participating in a group rating plan the previous year will not be used to disqualify the employer in future years.;
d. The employer must be in an active status as of the group rating application deadline and be in an active status at the beginning of the rating year. An employer who becomes active and obtains coverage or who lapses and does not reinstate its coverage by April first for private employers after the group rating application deadline may not participate in group rating for that year except as defined in rule 4123-17-66 of the Administrative Code.

C. In providing employer group plans under section 4123.29 of the Revised Code, the bureau shall consider an employer group as a single employing entity for purposes of group rating. No employer may be a member of more than one group for the purpose of obtaining workers' compensation coverage. Applying for more than one group on a valid application for group rating will result in rejection of the employer from all groups for which the employer applied.
D. A sponsoring organization for group rating shall satisfy all of the requirements for a sponsoring organization as required under section 4123.29 of the Revised Code and in this rule. A sponsoring organization shall submit to the bureau information to demonstrate that the organization meets the requirements for group sponsorship. The bureau shall review the information and shall register the sponsoring organization if it meets the requirements. A sponsoring organization shall register with the bureau prior to marketing to or soliciting employers for membership in a group under the group rating program.

4123-17-62 Application for group experience rating
eff. 7/1/01

A. A sponsoring organization shall make application for group experience rating on a form provided by the bureau and shall complete the application in its entirety with all documentation attached as required by the bureau. If the sponsoring organization fails to include all pertinent information, the bureau will reject the application.
   1. The group application shall be signed each year by an officer of the sponsoring organization to which the members of the group belong, and the sponsoring organization shall identify each individual employer in the group in the AC-25 application and shall provide information on each employer as follows:
      a. All employers which were in the group in the previous rating year. The employer does not need to file an AC-26 form.
      b. All employers which were not in the group in the previous rating year, but were in another group of the same sponsoring organization for the previous rating year. The employer does not need to file an AC-26 form.
      c. All employers which were not in the group in the previous rating year, and were not in another group of the same sponsoring organization for the previous rating year. The employer must file an AC-26 form for the group.
   2. In a separate report, or on the AC-25 form in a manner that clearly distinguishes the employers which are in the group from those which are not in the group, the sponsoring organization shall provide information on each employer as follows:
      a. All employers which were in the group in the previous rating year and are no longer in the group, but are in another group of the same sponsoring organization. The employer does not need to file an AC-26 form.
      b. All employers which were in the group in the previous rating year, are no longer in the group, and are not in another group of the same sponsoring organization. If the employer is participating in group rating with another sponsoring organization, the employer must file an AC-26 form for that group.
   3. An individual employer's application for group rating (AC-26) is applicable for the upcoming policy year and all subsequent policy years where the employer remains in the same group or another group sponsored by the same sponsoring organization. The employer does not need to file a new AC-26 each year where the employer remains in any group sponsored by the same sponsoring organization, whether it is the same group as the previous rating year or a new group of the same sponsoring organization. The employer must file an AC-26 if the employer applies for group rating with a different sponsoring organization or was not participating in group rating the previous rating year. Where an employer files a new AC-26 during an application period, it shall be presumed that the latest filed AC-26 of the employer indicates the employer's

intentions for group rating. The employer's AC-26 shall remain effective until any of the following occurs:

a. The employer timely files a subsequent AC-26 indicating the desire to participate in a group with a different sponsor for the upcoming policy year;
b. The sponsoring organization for the group does not include the employer on the group roster (AC-25);
c. The group does not reapply for group rating or is rejected for failure to meet group eligibility requirements; or
d. The employer fails to meet individual eligibility requirements and is rejected from participation in the group for the purpose of group rating by the bureau.

4. The bureau may request of individual employers or the group additional information necessary for the bureau to rule upon the application for group coverage. Failure or refusal of the group to provide the requested information on the forms or computer formats provided by the bureau shall be sufficient grounds for the bureau to reject the application and refuse the group's participation in group experience rating. Individual employers who are not included on the final group roster or do not have an individual employer application (AC-26) for the same group or another group sponsored by the same sponsoring organization on file by the application deadline will not be considered for the group plan for that policy year; however, the bureau may waive this requirement for good cause shown due to clerical or administrative error, so long as no employer is added to a group after the application deadline. All rosters, computer formats or typewritten, must be submitted by the application deadline.
5. A sponsoring organization shall notify an employer that is participating in a group of that sponsoring organization if the employer will not be included in a group by that sponsoring organization for the next rating year. For private employer groups, the sponsoring organization shall notify the employer in writing prior to December first of the year preceding the group application deadline. For public employer taxing district groups, the sponsoring organization shall notify the employer in writing prior to May first of the year of the group application deadline. If an employer notifies the bureau that a sponsoring organization has not complied with this rule and the sponsoring organization fails to prove that the notice was provided in a timely manner, the bureau will, without the approval of the sponsoring organization, allow the employer to remain in the group for the rating year for which the notice was required. If that group no longer exists the bureau will, without the approval of the sponsoring organization, place the employer in a homogeneous group with the same sponsoring organization or take other appropriate action.

B. For public employer taxing districts, applications for group coverage shall be filed on or before the last business day of June of the year immediately preceding the rating year. For private employers, applications for group coverage shall be filed on or before the last business day of January of the year of the July 1 beginning date for the rating year.
C. A group's application for group rating is applicable to only one policy year. The group must reapply each year for group coverage. Continuation of a plan for subsequent years is subject to timely filing of an application on a yearly basis and the meeting of eligibility requirements each year; however, an individual employer member of a continuing group who initially satisfied the homogeneous requirement of paragraph (B)(3) of rule 4123-17-61 of the Administrative Code shall not be disqualified from participation in the continuing group for failure to continue to satisfy such requirement.
D. The application shall be filed in the risk technical services section of the bureau of workers' compensation, 30 West Spring Street L22 Columbus, Ohio 43215.
E. The application for any group to participate in group experience rating is optional with the group, subject to acceptance by the bureau. Once a group has applied for group rating, the organization may not voluntarily terminate the application during the bureau's evaluation period. All changes to the original application must be filed on a bureau form provided for the application for the group experience rating plan and must be filed prior to the filing deadline. Any rescissions made must be completed in writing, signed by an officer of the organization to which the members of the group belong, and filed prior to the filing deadline. The group may make no changes in the application after the last day for filing the application. Any changes received by the bureau after the filing deadline will not be honored. The latest application form or rescission received by the bureau prior to the filing deadline will be used in determining the premium obligation.
F. In reviewing the group's application, if the bureau determines that individual employers in the group do not meet the eligibility requirements for group rating, the bureau will notify the individual employers and the group of this fact, and the group may continue in its application for group coverage without the disqualified employers, if the group still satisfies the minimum requirements for group rating as provided in rule 4123-17-61 of the Administrative Code.
G. After the group application deadline but before April first for a private employer group or before October first for a public employer taxing district group, the sponsoring organization may notify the bureau that it wishes to remove

an employer from participation in the group. The sponsoring organization may request that the employer be removed from the group after the application deadline only for the employer's gross misrepresentation on its application to the group.

1. "Gross misrepresentation" is an act by the employer that would cause financial harm to the other members of the group. Gross misrepresentation is limited to the following:
   a. Where the sponsoring organization discovers that the employer applicant for group rating has recently merged with one or more entities, such that the merger adversely affects the employer's experience modification and adversely affects the experience modification of the group, and the employer did not disclose the merger on the employer's application for membership in the group.
   b. Where the sponsoring organization discovers that the employer applicant for group rating has failed to disclose the true nature of the employer's business pursuit on its application for membership in the group, and this failure adversely affects the experience modification of the group.
2. The bureau shall review the request to remove the employer from the group, and the employer shall be removed from the group only upon the bureau's consent.

4123-17-63 Eligibility for group experience rating-size criteria
eff. 10/11/94

A. To be eligible for group experience rating, the group taken as a whole must include at least one hundred employers, each employer being identified as a separate risk for state fund identification purposes, or the group taken as a whole must be of sufficient size that the premiums of the members, as determined by the administrator, are expected to exceed one hundred fifty thousand dollars during the coverage period except as provided by paragraph C of this rule. The administrator may determine the aggregate premium of the members based upon the historical premium experience of the members, projected payroll, and anticipated premium rates. The evaluation period for determining aggregate premium shall be the rating year beginning two years prior to the coverage period.

B. For a group of less than one hundred members, the premium requirement shall be deemed to have been satisfied if the aggregate premium to the State Insurance Fund for the members of the group for the rating year beginning two years prior to the coverage period exceeded one hundred fifty thousand dollars except as provided by paragraph C of this rule. Failure to reach one hundred fifty thousand dollars in premium during the coverage period shall not negate the group coverage.

C. The bureau shall calculate the premium based upon the actual experience modified premium of the member employers during the evaluation period, including any modification due to group rating. The administrator may waive the requirement that premiums exceed one hundred fifty thousand dollars during the coverage period for a continuing group of substantially similar membership if the sole reason that the premium fails to exceed one hundred and fifty thousand dollars is due to the premium modification discounts earned by the group as a direct result of safety operations of the group rating program, and not due to other factors, such as a departure of members from the group or a reduction in payroll for members of the group.

4123-17-64 Group experience rate calculations
eff. 7/1/01

A. A group meeting all the requirements for group rating shall be considered as a single employing entity for purposes of group experience rating. The eligibility of data for use in the group shall be the same as the eligibility of data for use in the individual employer's rate calculation. Credibility limits and all factors based upon credibility will apply at the group level. For catastrophe claims, the definition of a catastrophe under paragraph (A) of rule 4123-17-12 of the Administrative Code must be satisfied by an individual employer in the group to be eligible for catastrophe claim cost relief, although more than one individual employer in the group may qualify for catastrophe relief from the same catastrophe occurrence. Handicap charges to surplus shall be applied at the group level.

B. All operations or manuals of a risk electing group rating are subject to group experience rating.

C. Effective July 1, 2002, except with respect to mergers or transfers of the operations of a business, an employer's experience may be combined once during a policy year to create an experience modification for multiple employers grouped together for experience rating purposes.

D. Employers participating in a group rating plan may implement the drug free workplace program and receive the associated premium discounts in addition to the group discount. However, the combined discounts may not exceed the maximum discount allowed under the group rating plan.

E. An employer that is in a cancelled coverage status for at least one full rating year as of the date that the experience

modification of a group of which it had been a member is recalculated, will not be liable for any obligation nor will such employer receive the benefit of any credit associated the recalculation.

4123-17-65 Experience retention for group experience rate calculation purposes
eff. 10/11/94

Effective for the rating year beginning July 1, 1995, for private employers, and the rating year beginning January 1, 1996, for public employer taxing districts, if an individual employer is a member of a group for group experience rating and leaves the group, the experience of that individual employer shall be used in experience-rating calculations for the group to impact only the rating years that the employer was a member of the group. The individual employer leaving the group retains its own experience rating incurred while a member of the group for the balance of the standard experience period. The group shall not be liable for claims experience incurred by an individual employer for claims occurring after the employer has left the group.

4123-17-66 Termination and transfers for group experience rating
eff. 7/1/01

This rule on termination and transfer of group experience rating shall apply at the group level after the bureau applies the applicable individual rules on transfer of experience.

A. A group formed for the purpose of group experience rating may not retroactively include experience in a plan, exclude experience from a plan, or voluntarily terminate a plan during the policy year. A change in the name of the group will not constitute a new group. A change of the organization sponsoring a group or moving a group to a new sponsoring organization shall constitute a new group and the members of the new group must meet the homogeneity requirement of paragraph (B)(3) of rule 4123-17-61 of the administrative code. The amendments contained in this paragraph of this rule shall be effective for rating years beginning July 1, 2002, and thereafter. A group will be considered a continuing group if more than fifty per cent of the members of the group in the previous rating year are members of the group in the current rating year.
B. Successor: files petition for bankruptcy
Predecessor: no predecessor
An individual employer which is a member of a group for the purpose of experience rating and which becomes a debtor-in-possession during the policy year shall remain a member of the group for the entire policy year.
C. Successor: entity not having coverage
Predecessor: group rated with employees and reported payroll
Where one legal entity not having coverage in the most recent experience period wholly or partially succeeds another legal entity in the operation of a business, and the predecessor entity was a member of a group for experience rating, the successor shall be considered a member of the group and the successor entity's rate shall be based on the group's experience, as long as the successor employer is homogeneous to the group. For a partial transfer, the effective date of the group experience transfer shall be on the first day of the next payroll reporting period (January first or July first).
D. Successor: group rated
Predecessor: experience rated (either individually or in a different group), or non-group base rated
Where a legal entity having established coverage is a member of a group for experience rating and wholly succeeds another legal entity, the successor entity shall remain a member of the group for experience rating and the experience of the predecessor shall be included with the experience of the group for the purpose of experience rating.
E. Successor: non-group rated
Predecessor: group rated
Where a legal entity having established coverage is a member of a group for the purpose of experience rating and is wholly succeeded by another legal entity which is not a member of the group, the successor entity shall not become a member of the group.
F. Successor: group rated
Predecessor: group rated
Where a legal entity which is a member of group for the purpose of experience rating wholly succeeds another legal entity which is also a member of the same group for the purpose of experience rating, the successor entity shall remain a member of the group for the purpose of experience rating.
G. Successor: group rated

Predecessor: self-insured
When an individual employer which has returned to the state insurance coverage from self-insured status and has used the self-insured experience in calculating the experience rate becomes a member of a group for the purpose of experience rating, the self-insured experience shall not be included in the experience of the group for rating purposes.

H. Successor group rated
Predecessor: non-group rated
Where a legal entity succeeds in the operation of a portion of a business of another legal entity and the successor entity is a member of a group for experience rating, the successor entity shall remain a member of the group for experience rating and the experience of the predecessor shall be included with the experience of the group for the purpose of experience rating. The effective date of the group experience transfer shall be on the first day of the next payroll reporting period (January first or July first).

I. Successor: non-group rated
Predecessor: group rated
Where a legal entity having established coverage succeeds in the operation of a portion of a business of another legal entity and the successor entity is not a member of a group and the predecessor is a member of a group for experience rating, the successor entity will not become a member of the group for experience rating and the predecessor will remain a member of the group.

J. Successor: entity not having coverage
Predecessor: group rated with no employees and no reported payroll
Where one legal entity not having coverage in the most recent experience period wholly or partially succeeds another legal entity in the operation of a business, and the predecessor entity was a member of a group for experience rating, the successor entity shall not become a member of the group unless and until the entity applies for membership in the group in the next experience period.

K. When any combination or transfer of experience is indicated, the effective date of such combination or transfer shall be the beginning date of the next following payroll reporting period. In cases where an entity not having coverage wholly succeeds another entity, the effective date shall be the actual date of succession.

L. An individual employer which is a member of a group for the purpose of experience rating may not participate in a retrospective rating plan during the policy year in which the employer is a member of the group.

4123-17-67 Representation for group experience rating
eff. 11/08/99

A. A group that has been established and has been accepted by the Bureau of Workers' Compensation for the purpose of group experience rate calculation shall have no more than one permanent authorized representative for representation of the group and the individual employers of the group before the bureau and the Industrial Commission in any and all risk-related matters pertaining to participation in the workers' compensation fund.

B. The selection of an authorized representative must be made by submission of a completed form AC-2, and any change or termination of the authorized representative can be made only by a subsequent submission of form AC-2. Only an officer of the group may sign an AC-2.

C. Notwithstanding the provisions of division A of this rule, an individual risk in a group may retain the services of an attorney or other authorized representative for claims-related matters, such as representation at claims hearings before the bureau and the Industrial Commission, through submission of the appropriate authorization for representation in such individual claim files. The bureau will recognize only one authorized representative for notice and appeal purposes.

4123-17-68 Group Experience Safety Program Requirements
eff. 07/01/01

A. The purpose of this rule is to establish minimum safety requirements for group experience rating as provided by section 4123.29 of the Revised Code.

B. The BWC division of safety and hygiene, upon the request of the sponsoring organization, shall provide assistance with implementing all of the provisions of this rule.

C. The sponsoring organization of a group shall document its program to improve accident prevention and claims handling for the employers in the group with the group application, and, for an existing group reapplying for group coverage annually, shall document the effectiveness of prior programs as stipulated in paragraph (D) of this rule and any proposed improvements to these programs.
1. Within sixty days after the application filing deadline, a bureau division of safety and hygiene loss prevention

representative shall review the group's safety program. The safety and hygiene representative shall contact the group sponsor or its authorized representative to assist in further developing an appropriate safety program if there are deficiencies in the program. All sponsoring organizations shall be required to sponsor a minimum of eight hours of safety seminar (or safety seminars) during the rating year for members of their group rating program. A bureau representative may attend these seminars to ensure the requirement is being met. If the requirement is not met, the sponsoring organization will be ineligible to sponsor a group rating program the following year.

2. The bureau safety and hygiene division shall make a recommendation to the bureau underwriting section on whether the group's safety program is acceptable for policy years beginning January 1, 1997. A copy of the recommendations and findings of the safety and hygiene division shall be mailed to the sponsoring organization or its authorized representative at the same time. The underwriting section shall consider this recommendation in making its decision whether to approve the group rating application at the time of renewal. The underwriting section shall notify the sponsoring organization of the necessary changes and provide the sponsoring organization fourteen days to resubmit its group safety program with the recommended changes.
3. The bureau safety and hygiene division shall evaluate the group's safety program at the sponsoring organization level and not at the individual member level.
4. If the bureau's underwriting section does not approve a group for group rating based upon the group's safety program, the sponsoring organization may request a hearing before the adjudicating committee pursuant to rule 4123-14-06 of the Administrative Code.

D. The following are guidelines and criteria that a sponsoring organization or its representative shall take into account in developing a safety program for its group members.
   1. The sponsoring organization shall utilize the following strategies to help group members improve safety efforts:
      a. Communication and education, as detailed in paragraph (E) of this rule;
      b. Linkage with the division of safety and hygiene, as detailed in paragraph (F) of this rule; and
      c. Communication and promotion of key safety program parameters, as detailed in paragraph (G) of this rule.
   2. Key success factors in managing safety by group member employers are:
      a. Leadership from management;
      b. Communication within and throughout the organization;
      c. Involvement of all employees in the safety process; and
      d. Training and education of employees and supervision in safety management and accident prevention.

E. Communication and education strategies of the sponsoring organization may include use of the following strategies: newsletters, seminars, consultants, videos, group-sponsored safety committees, personal contact, brochures, booklets, stickers, manuals, self-help documents, claims review and analysis, identifying key personnel within the sponsoring organization, and training in safety management for the sponsoring organization staff or representative.

F. Linkage of the group-sponsoring organization with the division of safety and hygiene may include the following strategies:
   1. The bureau shall link each sponsoring organization with a service representative from safety and hygiene.
   2. Safety and hygiene shall review and comment on group's safety plans.
   3. Safety and hygiene and the sponsoring organization may sponsor joint seminars.
   4. The sponsoring organization may use the safety congress to augment group safety communication and training.
   5. Safety and hygiene shall provide a list of resources and expertise within each region.
   6. The sponsoring organization may promote bureau safety and hygiene division training.
   7. Safety and hygiene may develop half day training sessions for remote locations.
   8. Safety and hygiene may provide written safety and hygiene safety and health materials to companies.
   9. The sponsoring organization may use bureau safety and hygiene division expertise to help companies improve the management of safety (direct consultation with top managers).
   10. Safety and hygiene may provide video teleconferencing of topic-related seminars.
   11. Safety and hygiene and the sponsoring organization may develop joint programs in response to member needs.

G. The sponsoring organization or its representative shall communicate, educate, and promote the following key safety program parameters to group members:
   1. A written safety and health policy signed by the top company official that expresses the employer's values

and commitment to workplace safety and health.
2. Visible senior management leadership that promotes the belief that the management of safety is an organizational value.
3. Employee involvement and recognition that affords employees the opportunity to participate in the safety management process.
4. A program of regular communications on safety and health issues to keep all employees informed and to solicit feedback and suggestions.
5. Orientation and training for all employees.
6. Published safe work practices so that employees have a clear understanding of how to safely accomplish their job requirements.
7. Assigning an individual the role of coordinating safety efforts for the company.
8. Early return-to-work strategies to help injured or ill workers return to work.
9. Internal program verification to assess the success of company safety efforts, to include audits, surveys, and record analysis.

H. The division of safety and hygiene shall schedule annual regional training seminars for sponsoring organizations. Each sponsoring organization must send at least one representative to the seminar. Additionally, the division of safety and hygiene shall develop a list of publications and support materials that assist the sponsoring organization in reinforcing the safety guidelines of this rule.

4123-17-70 Premium discount program plus

eff. 10/14/02

A. Pursuant to division (E) of section 4123.34 of the Revised Code, the administrator may grant a discount on premium rates to an eligible employer who meets the loss prevention program requirements under the provisions of this rule.
   1. For private employers, the premium discount program plus (PDP plus) application may be submitted at any time. The employer shall file the application with the bureau by thirty five days after the bureau's publication of the employer's individual experience modification. If the application is not received by this time, the employer's participation and discounts are to begin on the next payroll period beginning on either January first if the application is received by December 31, or on July first if the application is received by June 30.
   2. For public employer taxing districts, the application may be submitted at any time. The employer's participation and discounts are to begin on next payroll period beginning on January first.

B. An employer's opportunity to participate in PDP plus will be limited to three consecutive twelve month years.
   1. If an employer is ineligible for PDP plus in its second year, the employer may reapply for its third year of participation and receive a five per cent discount if the employer is eligible under paragraph (C) of this rule.
   2. If an employer opts out of PDP plus after the start of a policy year, the employer will no longer be eligible for the PDP plus program.
   3. Notwithstanding paragraphs (B)(1) and (B)(2) of this rule, a private employer enrolled in the original premium discount program prior to July 1, 2001, will have until June 30, 2004 to complete four years of participation in PDP. A public employer taxing district employer enrolled in the original premium discount program prior to July 1, 2001, will have until December 31, 2004 to complete four years of participation in PDP. If the employer maintains its eligibility it may continue in the PDP until it has completed four years of participation. However, no employer will be allowed more than seven years from the original date of entry in PDP to complete the four years of eligibility.

C. The PDP plus program under this rule is available to any employer who satisfies all of the following eligibility requirements. The bureau shall determine whether the employer is eligible for PDP plus under this rule.
   1. The employer must be experience rated pursuant to rule 4123-17-03 of the Administrative Code. That is, the employer must have an Experience modification (EM) of .90 per cent or greater for the policy year of the program.
   2. The employer cannot participate in either group or retrospective rating in the same policy year as the PDP plus under this rule.
   3. The employer must be current as of the beginning of the policy year or anniversary date of participation (not more than forty-five days past due) on any and all premiums, assessments, fines or monies otherwise due to any fund administered by the bureau, including amounts due for retrospective rating.
   4. The employer cannot have cumulative lapses in workers' compensation coverage in excess of fifty-nine days within the eighteen months preceding the beginning of the policy year or anniversary date of participation.
   5. The employer must be in an active status the first day of the policy year or anniversary date of participation for PDP plus.

(D) If the bureau determines that an employer is eligible to participate in PDP plus under this rule, the employer must comply with the following loss prevention requirements for initial participation and continuation of participation in the program.
1. The employer must participate in and comply with the ten step business plan as provided in paragraph (E) of this rule.
2. The employer must permit the bureau access to the employer's job sites to review the employer's safety program and safety progress.
3. The employer must agree to submit to the bureau, or if working through a bureau certified sponsor as provided in paragraph (F) or paragraph (O) of this rule, to its certified sponsor, a PDP plus plan of action identifying the activities the employer has performed with regard to the ten step business plan within the past year and the planned improvements for the next year.
   a. For continuation, the risk division or bureau certified sponsor will evaluate the employer's effectiveness in establishing the ten step business plan. The evaluation of each step will be based on an employer's written plan of action indicating and documenting that the employer has substantially implemented or maintained each step of the ten step business plan or that the employer has not substantially implemented or maintained them. The employer shall immediately submit any additional documentation of implementation to the evaluator on request.
   b. Employers not submitting a bureau approved plan of action will lose the premium discount for the entire year. A private employer plan of action document is due to the bureau no later than March 31 for participants having a July first effective date, or by September 30 for participants having a January first effective date. A public employer taxing district employer plan of action document is due no later than September 30, except for public school districts, which are due by November 15.
4. A participating employer must use the bureau standardized plan of action form when submitting its plan of action during the first and second years of participation in the program. The employer must submit, at a minimum, a plan of action for each of the five steps the employer is completing for that year. An employer in the third year of the program will not be required to submit a new plan of action. However, the employer's earning the discount for the second and third year in the program is contingent upon passage of all ten steps and performance measure improvement, such as a reduction in claims frequency, claims severity, claims cost, or experience modification, or a combination of any of these factors. A first year employer earns the discount by filing a plan of action and documenting the implementation of these steps.

E. The employer must implement the ten step business plan prescribed by the superintendent of the division of safety and hygiene as provided in this rule. The ten steps of the business plan and their point value for evaluation are as follows:
1. Visible senior management leadership that promotes the belief that the management of safety is an organizational value.
2. Employee involvement and recognition that affords employees the opportunity to participate in the safety management process.
3. Early return-to-work strategies to help injured or ill workers return to work.
4. A program of regular communications on safety and health issues to keep all employees informed and to solicit feedback and suggestions.
5. Timely notification of accidents, including lag time reporting standards. Under the health partnership program, an employer must immediately report its claims to its managed care organization.
6. Assigning an individual the role of coordinating safety efforts for the company. The coordinator shall attend a bureau safety and hygiene course or a bureau approved safety course and shall document the attendance to the bureau. An employee designated as the accident prevention coordinator who has a bureau recognized health and safety credential (CSP, CIH, CIE, or any other comparable safety certification) is exempt from mandatory attendance at a safety course under this paragraph. If the employer is exempt, the employer shall submit a copy of the certificate of the employee's such designation.
7. Writing an orientation and training plan for all employees.
8. Publishing a general and job specific safe work practices document so that employees have a clear understanding of how to safely accomplish their job requirements.
9. Publishing a written safety and health policy document signed by the top company official that expresses the employer's values and commitment to workplace safety and health.
10. Internal program verification to assess the success of company safety efforts, to include audits, surveys, and record analysis.

F. The bureau or the employer's bureau certified sponsor will evaluate the employer's compliance with all ten steps of the ten step business plan based upon the employer's plan of action report and supporting documentation and information on the progress of the implementation of the ten step business plan.

1. An employer will be required to complete steps one, two, and six of the ten step business plan under paragraph (E) of this rule, to include mandatory attendance at bureau pre-approved sessions to include the OCOSH course entitled “controlling workers’ compensation costs,” workers' compensation university, safety congress and other pre-approved private and public courses deemed comparable by the bureau, during the first year and complete any two of the remaining seven steps to qualify for program continuation. The employer’s attendance at a ten step business plan workshop is strongly encouraged for the employer to properly complete the plan of action.
2. Every year thereafter, the employer shall continue with the first five steps the employer selected and complete the remaining five steps during the second year of participation to qualify for program continuation. The employer shall continue all ten steps during the third year of participation.
3. The bureau may perform special underwriting analysis of the employer. The bureau will monitor loss frequency, (number of medical only and lost time claims by calendar year), severity, experience modification, and lag time statistics as indicators to determine the employer’s progress whether administered by the bureau or its certified sponsors.
4. The premium discount program plus (PDP plus) is an enhancement to the original premium discount program where an employer may receive additional discounts over and above the discounts stated in paragraph (I)(1) of this rule.
5. The PDP plus program is available to an employer participating in the program where the employer has successfully implemented the ten step business plan under paragraph (E) of this rule.
6. PDP plus commences July 1, 2001, where discounts are dependent on the employer’s completion of the ten step business plan, and additional credits are allowed for a fifteen per cent reduction of claims frequency and for a fifteen per cent reduction of claims severity.
7. Claims frequency is defined as total number of reported claims (medical only and lost time) in a given policy year multiplied by one million dollars divided by the reported payroll of the same year.
8. Claims severity is defined as the total number of days away from work in a given policy year multiplied by one million dollars divided by the reported payroll of the same year.
9. In calculating the total number of days away from work, a permanent total disability claim or a death claim will be counted as resulting in a full 365 days away from work. A settlement will shorten the 365 days if settled as of the end of the policy period.
10. A PDP plus participant will be provided base line data of claims frequency and claims severity within the first thirty to forty-five days of starting the program. The data will compare one policy year to the following policy year. A new participant will be compared to the year prior to its entry into PDP. A participant in subsequent years will be compared to the prior policy year.
11. A PDP plus participant will be provided annual updates on its claims frequency or claims severity improvement or regression within thirty to forty-five days after the end of the policy period.
12. If an employer participating in PDP plus after two years has not shown improvement in either claims frequency or claims severity measurements, the employer may be removed from PDP plus at the discretion of the bureau.

G. If the bureau disqualifies an employer from PDP plus under this rule for failure to perform the ten step business plan or to demonstrate statistical improvement under paragraph (F)(3) of this rule, the employer will be ineligible to reapply for the discount program for a period of one year and will not be eligible for PDP plus discounts.

H. An employer who is found to be ineligible for participation in PDP plus may reapply in subsequent years subject to the three year limitation under paragraph (J) of this rule, unless the employer is ineligible to reapply due to disqualification based upon paragraph (L) of this rule.

I. An employer participating in PDP plus with an experience modification of .90 or greater shall be eligible to receive premium discounts as provided for in this rule.
   1. The premium discount shall be as follows:
      a. For the first year of participation, ten per cent;
      b. For the second year of participation, ten per cent;
      c. For the third year of participation, five per cent;
      d. For the fourth year of participation for any employer enrolled in the original premium discount program prior to July 1, 2001, as provided in paragraph (B)(3) of this rule, five per cent.
      e. An employer who is experience rated with an experience modification of .90 to 1.00 (not to include a base rated employer) will be eligible for the credits associated with meeting the claims frequency and claims severity goals.
      f. The premium discount may not bring the employer's premium below an amount of premium that would be caculated using an experience modification of .90 for the policy year the discount is applied.
   2. The PDP plus discount will be applied to the base premium rate, but not to the disabled workers’ relief fund

assessments or other assessments. The premium discount will not alter the employer's actual experience modification calculation under rule 4123-17-03 of the Administrative Code.

3. PDP plus discounts are as follows:
   a. Ten per cent for a fifteen per cent or greater claims severity reduction;
   b. Five per cent for a fifteen per cent or greater claims frequency reduction;
   c. Five per cent bonus for meeting both a fifteen per cent or greater claims severity reduction and a fifteen per cent or greater claims frequency reduction.
4. A PDP plus discount check will be sent to an employer by the end of October for an employer whose anniversary date in PDP plus is the first of July, and by the end of April for an employer whose anniversary date in the program is the first of January.
5. An employer whose experience modification becomes .89 or less for any reason at any time during any year of participation in the program will not be eligible for the discount under this program.

J. If an employer reapplies for PDP plus after skipping the second year of PDP plus participation, whether the employer was eligible or ineligible for PDP plus, the employer will be considered in year three and receive the five percent discount.
   1. An employer is limited to three years to complete its participation in PDP plus under this rule. Discounts with or without breaks in participation are as provided in paragraph (I) of this rule. An employer with breaks in participation must reapply by application.
   2. A participating employer must complete the remaining five steps of the plan of action.
   3. An employer who has completed its three years of participation in PDP plus under this rule is ineligible to reapply for the program.

K. An employer participating in the PDP plus program who becomes ineligible after completing one half year of a rating year of participation will be considered as using an entire year of participation.

L. An employer may withdraw the application for enrollment in PDP plus under this rule anytime prior to the enrollment deadline. An employer that has denied site access to the bureau, failed to submit a ten step plan of action, or voluntarily opted out of the program will not be permitted to reapply for the PDP plus at any time in the future.

M. An employer may appeal enrollment rejection and continuation rejection to the adjudicating committee pursuant to rule 4123-14-06 of the Administrative Code.

N. If there is a combination or experience transfer resulting in a new policy number, the successor employer is not eligible for participation in PDP plus unless the successor employer made application during the premium year in which the combination took place.

O. The bureau may grant certification as a program sponsor to any trade or business association or its authorized representative that satisfies all of the following eligibility requirements. The bureau shall determine whether the association or its agent is eligible for certification as a program sponsor under this rule. An association or its agent that is found to be ineligible to be a certified program sponsor may reapply in subsequent years. The sponsor shall:
   1. Have been in existence for at least two years prior to the last date upon which a request for certification can be filed.
   2. Have at least two years experience in assisting Ohio employers in accident prevention and claims management.
   3. Have on staff or unlimited access to a practicing safety and health professional, excluding bureau personnel, with at least five years experience working full-time in accident prevention.
   4. Sign an agreement with the bureau to fully support the basic principles associated with managing occupational safety in accordance with the bureau's ten step business plan. The agreement must indicate the commitment of the association or its agent to the criteria for continued participation as specified in paragraph (P) of this rule.

P. Any trade or business association or its authorized agent meeting the above eligibility requirements must submit documentation supporting all eligibility requirements to the bureau's superintendent of the division of safety and hygiene for certification. The deadline for submitting the documentation and credentials for certification is June fifteenth.

Q. If the bureau determines that a trade or business association or its authorized agent is eligible to be a certified sponsor under this rule, the association or its agent must comply with the following standards. The sponsor shall:
   1. Include in the agreement or contract to provide services under this program to a sponsored employer, in bold type, that the services provided under this agreement or contract by the sponsor are available at no additional fee to the employer from the bureau of workers' compensation.
   2. Send the sponsor's safety and health professional to attend a bureau sponsored course or seminar on basic safety principles and the ten step business plan prior to certification.

3. Send the sponsor's safety and health professional to attend an annual safety conference sponsored by the bureau's division of safety and hygiene.
4. Hold an annual full-day conference on managing safety and claims for all sponsored employers. An attending employer is to complete the bureau's plan of action for all ten steps indicating what actions the employer will complete to fulfill the ten step business plan.
5. Communicate at least quarterly to all sponsored employers current and pertinent safety and health information.
6. Communicate at least quarterly to all sponsored employers specific guidance on implementing and maintaining the ten step business plan.
7. Annually assess the safety perceptions and safety needs of each sponsored employer and adjust its approach to meet each employer's needs.
8. Notify the bureau of a change in its safety and health professional and apply for re-certification at that time.
9. Submit a complete list, in the format provided by the bureau, containing each sponsored employer's policy number, name, and federal employer identification number in policy number order, of all private employers it will sponsor annually to the bureau by June fifteenth for those employers that began the program on July first and by December fifteenth for those employers that began the program on January first. This requirement does not alter the employer application deadline for the premium discount program under this rule as provided in paragraph (A) of this rule.
10. Submit a complete list, in the format provided by the bureau, containing each sponsored employer's policy number, name, and federal employer identification number in policy number order, of all public employer taxing districts it will sponsor annually to the bureau by December fifteenth. This requirement does not alter the employer application deadline for the premium discount program under this rule as provided in paragraph (A) of this rule.
11. Assist all sponsored employers in implementing and complying with the bureau's ten step business plan.
12. Objectively evaluate the plan of action report of all sponsored employers using the evaluation guidelines outlined in paragraphs (D) and (E) of this rule.
13. Submit a list, in the format provided by the bureau, containing each sponsored employer's policy number, name, federal employer identification number, and an indication of the pass or fail for each employer, in policy number order, of all private employers to the bureau by June first and December first.
14. Submit a list, in the format provided by the bureau, containing each sponsored employer's policy number, name, federal employer identification number, and the indication of the pass or fail for each employer, in policy number order, of all public employer taxing districts to the bureau by December first.
15. Submit to the bureau upon request the plan of action report, evaluation score justification, and any other documentation, such as safety audits, that will support the analysis of the sponsored employer.
16. Safety professionals of A certified sponsor must make at least one on-site consultation during each year of an employer's participation. Documentation of discussions with an employer official or employer representative during a visit shall be furnished to the bureau on request.
17. A certified sponsor must write a letter of instruction to each employer desiring to switch to bureau PDP plus sponsorship and shall immediately provide a copy to the bureau.

R. The bureau retains all rights provided under paragraph (D) of this rule with respect to all certified sponsored employers.

S. The bureau may de-certify a trade or business association or its authorized agent as a sponsor under this program for the following:
   1. Failure to meet requirements as outlined in paragraph (Q) of this rule.
   2. Falsification of an evaluation or assessment.
   3. Incorrectly evaluating more than ten per cent of the employer evaluations in any one year.
   4. Failure to notify the bureau within thirty days of a change in safety and health professionals.
   5. Failure to apply for re-certification within thirty days of a change in safety and health professionals.

4123-19-01 Definition: State Risks, Self-Insuring Risks
eff. 11/19/93

A. "State Risks" are hereby defined as those employers who pay their full premium into the State Insurance Fund.

B. "Self-Insuring Risks" are hereby defined as those employers who are of sufficient financial ability to carry their own insurance; who do not desire to insure the payment thereof, except as provided in Division (B) of Section 4123.82 of the Revised Code; who secure authority from the Administrator of the Bureau of Workers' Compensation to pay compensation, etc., directly; who pay into the State Insurance Fund an assessment as established by a rule of the Bureau of Workers' Compensation adopted in accordance with Section 111.15 of the

Revised Code; who pay to the bureau a contribution to the self-insuring employers' guaranty fund pursuant to section 4123.351 of the Revised Code; and who provide an additional security, where required by the bureau, in the amount or form that may be specified by the bureau.

C. "Self-insurance" is a privilege granted or denied by the Administrator of the Bureau of Workers' Compensation. Once granted the privilege of Self-Insurance, the employer determines the first level of a claim and must have employees with a working knowledge of current Ohio Workers' Compensation law and all rules and regulations of the Bureau of Workers' Compensation and the Industrial Commission. A self-insuring employer may, without any prior order from the commission or bureau, grant or refuse to grant, any claim made under the Ohio Workers' Compensation Act. In granting a claim or awarding payment of compensation or benefits, the employer may provide to its employees compensation or benefits which are greater than those required by law. The employer may not pay compensation or benefits less than that which is required by law.

4123-19-02 General procedures in the processing of applications for industrial coverage
eff. 05/09/90

A. To secure the initial quotation of rate and premium, the employer shall complete and return to the Columbus Central Office of the Bureau of Workers' Compensation an application prepared by the bureau and entitled "Application for Classification of Industry and Premium." Blank forms of this applicant will be mailed to the employer upon request to the bureau and such form(s) must be used in making such application.
B. Upon receipt of the completed application as indicated under paragraph A of this rule, the bureau shall forthwith issue a premium advice and pay-in-order on the same, setting forth the classification, rate and thirty percent of the eight months' premium security deposit of the applicant, not to exceed one thousand dollars and not less than ten dollars.
C. Two copies of the premium advice and pay-in-order shall be forwarded to the employer.
D. In the event the applicant has one or more employees and intends to become a State Risk, then such applicant, upon receipt of the pay-in-order, shall immediately forward such pay-in-order together with the amount of money specified therein to the Treasurer of State or to the Bureau of Workers' Compensation.
E. The applicant's protection shall date from the time the payment of the premium security deposit is actually received by the Treasurer, State of Ohio, or bureau, or the date the written binder of new coverage has been approved.
F. Upon the receipt of the employer's premium security deposit, the accounting section shall issue forthwith to the employer a "Certificate of Premium" statement. Such statement shall certify to the employer that the employer has paid into the State Insurance Fund the premium due according to the law and the rules of the bureau, and that said applicant is entitled to the rights and benefits of said fund beginning from the date such insurance became effective, such date being inserted in this statement, for a period as indicated on the statement.
G. Coverage that is extended to a person who in his household employs household worker(s) pursuant to Section 4123.01 of the Revised Code does not include such person himself.
H. Any employer who makes the semi-annual premium payment at least one month prior to the last day on which such payment may be made without penalty shall be entitled to a discount at such rate as the bureau may from time to time declare.

4123-19-03 Where an employer desires to secure the privilege to pay compensation, etc., directly
eff. 12/17/01

A. All employers granted the privilege to pay compensation directly shall demonstrate sufficient financial strength and administrative ability to assure that all obligations under Section 4123.35 of the Revised Code will be met promptly. The Administrator of the Bureau of Workers' Compensation shall deny the privilege to pay compensation, etc., directly , where the employer is unable to demonstrate its ability to promptly meet all the obligations under the rules of the commission and bureau under Section 4123.35 of the Revised Code. The Administrator shall consider, but shall not be limited to the following factors where they are applicable in determining the employer's ability to meet all obligations under Section 4123.35 of the Revised Code.
    1. In determining whether to grant a waiver of the requirement Division (B)(1)(E) of section 4123.35 of the Revised Code for certified financial records, the administrator shall consider the following criteria and conditions.
        a. The administrator shall require reviewed financial statements, including full footnote disclosure, to be prepared and submitted in accordance with generally accepted accounting principles. For the purposes of this rule, "Reviewed financial statements" shall mean financial statements that have been subject to procedures performed by a certified public accountant in accordance with AICPA Professional Standards,

specifically, Statements on Standards for Accounting and Review Services, Section 100, Paragraph .24 through .38, December 1978.

b. The administrator may utilize the services of a commercial credit reporting bureau to assist in the evaluation of an applicant's ability to meet its workers' compensation obligations. The cost of the commercial reporting service shall be assumed by the applicant employer.

c. Notwithstanding the above criteria, the administrator may deem it necessary for an applicant employer to provide additional security to ensure meeting its workers' compensation obligations, the amount of such additional security shall be in the form and amount as determined by the administrator and paid prior to the granting of self-insurance. Pursuant to paragraph (G) of this rule, in the event of the default of the self-insuring employer, the bureau shall first seek reimbursement from the additional security, which shall be first liable and exhausted, before payment is made from the self-insuring employer's guaranty fund under section 4123.351 of the Revised Code.

2. The administrator shall not grant the status of self-insuring employer to the state, except that the administrator may grant the status of self-insuring employer to a state institution of higher education excluding its hospitals.

B. The employer shall secure from the Bureau of Workers' Compensation proper application form(s) for completion. The completed application shall be filed with the bureau at least ninety days prior to the effective date of the employer's requested status as a Self-Insurer. The administrator may require that the application be accompanied by an application fee as established by bureau resolution to cover the cost of processing the application in accordance with Section 4123.35 of the Revised Code. The application shall not be deemed complete until all required information is attached thereto. Prior to presentation to the administrator, applicable items listed in division (B)(1) and (B)(2) of section 4123-35 of the Revised Code shall be made available to the bureau and shall be reviewed by the Bureau of Workers' Compensation. The bureau shall only accept applications which contain the required information.

C. The bureau shall recognize only such application forms which provide answers to all questions asked and furnish such information as may be required.

D. Upon return of completed forms referred to above, the application will be reviewed by the Administrator within a reasonable time.

1. If the Administrator determines to grant the privilege of self-Insurance, the bureau shall issue a "Finding of Facts" statement which has been prepared by the bureau, signed by the administrator, subject to all conditions outlined in paragraph (L)(3) of the rule.

2. If the Administrator determines not to grant the privilege of Self-Insurance, the bureau shall so notify the employer, whereupon the employer shall be required to continue to pay its full premium into the State Insurance Fund.

E. All employers, that have secured the privilege to pay compensation, etc., directly, will be required to make contributions as determined by the administrator to the self-Insuring employers' guaranty fund established under section 4123.351 of the Revised Code and, if an additional security is required by the bureau, in the amount and form that may be specified by the bureau. If additional security is in the form of a Surety Bond, the bond shall be from a company approved by the bureau and authorized to do business in the State of Ohio by the Ohio Department of Insurance. The Surety Bond shall be in the form prescribed by the bureau. The penal amount of such additional security is to be fixed by the administrator.

F. The surety bond or additional security furnished by the employer shall be for an amount and period as established by the bureau and may be periodically reviewed and reevaluated by the bureau. The Surety Bond or additional security shall provide on its face that the surety shall be responsible for the payment of all claims where the cause of action, as determined by the date of injury or date of occupational disease, arose during the liability of the surety bond or additional security. The liability under the Surety Bond or additional security and the rights and obligations of the surety shall be limited to reimbursement for the amounts paid from the surplus accounts of the State Insurance Fund by reason of default of the Self-Insuring employer in accordance with Division (B) of Section 4123.82 of the Revised Code; however, in the event of such Self-Insuring employer's default, the bureau shall first seek reimbursement from the Surety Bond or additional security, which shall be first liable and exhausted, before payment is made from the Self-Insuring employer's guaranty fund established under Section 4123.351 of the Revised Code. Upon default of the Self-Insuring employer, it shall be the responsibility of the Administrator of the Bureau of Workers' Compensation to represent the interests of the State Insurance Fund and the self-insuring employers' guaranty fund. The administrator, on behalf of the self-insuring employers' guaranty fund, has the rights of reimbursement and subrogation and shall collect from a defaulting self-insuring employer or other liable person all amounts the bureau has paid or reasonably expects to pay from the guaranty fund on account of the defaulting self-insuring employer.

G. The security herein required to be given by the employer shall be given to the State of Ohio, for the benefit of

the disabled or the dependents of killed employees of the employer filing the same, and shall be conditioned for the payment by the employer of such compensation to disabled employees or the dependents of killed employees of such employer, and the furnishings to them of medical, surgical, nursing and hospital attention and services, medicines and funeral expenses equal to or greater than is provided by the Ohio Workers' Compensation Law and for the full compliance with the rules and regulations of the commission and the bureau and rules of procedure.

H. If another parent corporation or entity owns more than fifty percent of the stock of an employer, such employer must furnish a contract of guaranty executed by the ultimate domestic parent corporation or entity. If the employer establishes to the bureau that such contract of guaranty cannot be given by the ultimate domestic parent corporation, then the bureau may, in its discretion, waive the requirement of a contract of guaranty. The bureau may require an alternative form of security.

I. From the effective date of this rule, employees having one or more years of experience as a workers' compensation administrator for a Self-Insuring employer in Ohio shall be deemed sufficiently competent and knowledgeable to administer a program of Self-Insurance. Those Self-Insuring employers that employ workers' compensation administrators who have less than one year of experience as a workers' compensation administrator in Ohio shall not have its status as a Self-Insuring employer affected pending notification by the Bureau of Workers' Compensation as to whether mandatory attendance of the administrator at a Bureau of Workers' Compensation training program is required. If the bureau determines that the administrator is not able to administer a Self-Insuring program, the bureau may direct mandatory attendance of the administrator at a Bureau of Workers' Compensation training program until such time as the bureau determines that the administrator is sufficiently competent and knowledgeable to run such a workers' compensation program. The cost of the bureau's training of the administrator(s) under this rule will be borne by the Self-Insuring employer applicant. By accepting the privilege of Self-Insurance, an employer acknowledges that the ultimate responsibility for the administration of workers' compensation claims in accordance with the law and rules of the Bureau of Workers' Compensation and the commission rests with that employer. The Self-Insuring employer's records and compliance with the Bureau of Workers' Compensation and commission rules shall be subject to periodic audit by the Bureau of Workers' Compensation.

   A Self-Insuring employer or applicant shall designate one of its Ohio employees who is knowledgeable and experienced with the requirements of the Ohio Workers' Compensation Act and rules and regulations therein, as administrator of its Self-Insuring program. The requirement for an Ohio administrator may be waived at the discretion of the bureau. The name and telephone number of the Ohio administrator, or non-Ohio administrator where the Ohio requisite has been waived, shall be posted by the employer in a prominent place at all the employer's locations. The Administrator's duties shall include, but not be limited to:

   1. Acting as liaison between the employer, the Bureau of Workers' Compensation and the Industrial Commission, and providing information to the agency upon request;
   2. Providing assistance to claimants in the filing of claims and applications for benefits;
   3. Providing information to claimants regarding the processing of claims and the benefits to which claimants may be entitled;
   4. Providing the various forms to be used in seeking compensation or benefits;
   5. Accepting or rejecting claims for benefits;
   6. Approving the payment of compensation and benefits to, or on behalf of claimants pursuant to paragraph (K) of this rule.

   This rule is not intended to prevent the hiring of an attorney or representative to assist the employer in the handling and processing of workers' compensation claims.

J. Employers that are granted the privilege of paying compensation, etc., directly, in accordance with these rules and regulations shall file with the bureau a report of paid compensation annually, shall keep a record of all injuries and occupational diseases resulting in more than seven days of temporary total disability or death occurring to its employees and report the same to the bureau upon forms to be furnished by it, and shall observe all the rules and regulations of the commission and the bureau and their rules of procedure with reference to determining the amount of compensation, etc., due to the disabled employee or the dependents of killed employees, and payment of the same. Any employer granted the privilege of paying compensation, etc., directly on or after July 1, 2001, shall report its paid compensation electronically via the bureau's web site. Effective January 1, 2002, all employers that have been granted the privilege of paying compensation, etc., directly shall report paid compensation electronically via the bureau's web site.

K. Minimal level of performance as a criterion for granting and maintaining the privilege to pay compensation directly:

   1. The employer must be able to furnish or make arrangements for reasonable medical services during all working hours. A written explanation of what arrangements have been made or will be made to provide

medical treatment shall be supplied with the application for Self-Insurance.

2. The employer shall promptly pay the fees of outside medical specialists to whom the commission or the bureau shall refer claimants for examination or where the commission or bureau refers the claim file for review and opinion by such specialist except as provided by law in cases where the claim was subsequently disallowed. Such fees shall be paid within the time limits provided for payment of medical bills under paragraph (K)(5) of this rule.
3. Every employer shall keep a record of all injuries and occupational diseases resulting in more than seven days of total disability or death as well as all contested or denied claims and shall report them to the bureau, and to the employee or the claimant's surviving dependents in accordance with Rule 4123-03-03 of the Administrative Code.
4. The employer shall file with the claimant and the bureau or the commission medical reports relating thereto and received by it from the treating physician and physicians who have seen the claimant in consultation for the allowed injury or occupational disease, or any injury or occupational disease for which a claim has been filed. The claimant shall file with the employer and the bureau or the commission medical reports relating thereto and received from the treating physician and physicians who have seen the claimant in consultation for the allowed injury or occupational disease or any injury or occupational disease for which a claim has been filed. The claimant shall honor the employer's request for appropriate written authorization to obtain medical reports to the extent that such reports pertain to the claim.
5. The employer shall pay hospital, medical, nursing and bills for medication duly incurred by the claimant within thirty days after receipt of such bill or an order from the bureau or the commission to do so unless the employer contests any of such matters, in which case it shall immediately notify the employee and the bureau or the commission in writing. The employer's notification to the employee shall indicate that the employee has the right to request a hearing before the industrial commission. The employer shall pay compensation due and payable under an order no later than twenty-one days after receipt of the order to do so. If the Self-Insuring employer allows a claim for benefits or compensation without a hearing, the employer shall pay such benefits or compensation no later than twenty-one days from acquiring knowledge of the claim or the claimant's filing of the C-84 form, whichever is later. The employer shall approve a written request for a change of physicians within seven days of receipt of such request that includes the name of the physician and proposed treatment. The employer shall approve or deny a written request for treatment within ten days of the receipt of the request. If the employer fails to respond to the request, the authorization for treatment shall be deemed granted and payment shall be made within thirty days of receipt of the bill.
6. The employer shall make its records and facilities available to the employees of the bureau at all reasonable times during regular business hours. A public employer shall make the reports required by section 4123.353 of the Revised Code available for inspection by the administrator of workers' compensation and any other person at all reasonable times during regular business hours..
7. The employer shall pay all compensation as required by the workers' compensation laws of the State of Ohio. By becoming Self-Insuring, the employer agrees to abide by the rules and regulations of the bureau and the commission and further agrees to pay compensation and benefits subject to the provisions of these rules. The Self-Insuring employer shall proceed to make payment of compensation or medical benefits without any previous order from the bureau or commission and shall start such payments as required under the Workers' Compensation Act, unless it contests the claim.
8. The employer may notify the medical section and the claimant at least sixty days prior to the completion of the payment of two hundred weeks of compensation for temporary total disability with the request that the claimant be scheduled for examination by the medical section. Payment of temporary total disability compensation after two hundred weeks shall continue uninterrupted until further order of the commission up to the maximum required by law, unless the claimant has returned to work, or the treating physician has made a written statement that the claimant is capable of returning to his former position of employment or that the disability has become permanent, or after hearing, an order is issued approving the termination of temporary total disability compensation.
9. Upon written request by the claimant or claimant's representative, the employer shall make available for review all the employer's records pertaining to the claim. Such review is to be made at a reasonable time (not to exceed seventy-two hours) and place. The claimant, upon written request, shall provide the employer or its representative with an appropriate written authorization to obtain medical reports and records pertaining to the claim.
10. The employer shall inform a claimant, and the Bureau of Workers' Compensation, in writing, within thirty days from the filing of the claim, as to what conditions it has recognized as related to the injury or occupational disease and what, it any, it has denied. The same timeframe shall apply when the employer rejects a medical only claim.

11. The employer shall post notices of its Self-Insuring status indicating the location in the plant(s) for the filing of a claim and the job title and department of the employee(s) designated by the employer to be the person or persons responsible for the processing of workers' compensation claims.
12. A public employer, except for a board of county commissioners described in division (G) of section 4123.01 of the Revised Code, a board of a county hospital, or a publicly owned utility, who is granted the status of self-insuring employer pursuant to section 4123.35 of the Revised Code shall comply with the section 4123.353 of the Revised Code.

L. If a state insurance fund employer or a succeeding employer, as described in rule 4123-17-02 of the Administrative Code, applies for the privilege of paying compensation, etc., directly, by transferring from state fund to self-insurance, the actuary of the bureau shall determine the amount of the liability of such employer to the bureau for its proportionate share of any deficit in the fund. To determine an employer's liability under this rule, the actuary of the bureau shall develop a set of factors to be applied to the pure premium paid by an employer on payroll for a seven year period, as described below. The factors shall be based on the full past experience of the Commission and Bureau as reflected in the most recent calendar year end audited combined financial statement of the Commission and Bureau, and shall also accommodate any projected change in the financial condition of the fund for the current calendar year, or any additional period for which an audited combined financial statement is unavailable. The factors shall be revised annually effective July first based on the most recent calendar year audited combined financial statement and the projected change in the financial condition of the fund in the current calendar year or any additional period for which an audited combined financial statement is unavailable. The annually revised factors shall be adopted by rule 4123-17-40 of the Administrative Code, and filed with the Secretary of State and the Legislative Service Commission at least ten days prior to July first of each year. Factors effective July first of each year shall apply to all applications for self-insurance filed on or after July first of that year through June thirtieth of the following year. The revised factors shall be applied to the pure premium paid by the employer on payroll for the seven calendar accident years ending December thirty-first of the year preceding the year in which the factors are adopted under rule 4123-17-40 of the Administrative Code. In the event the audited combined financial statement of the Commission and Bureau reveals that no deficit exists, or in the event the application of the factors adopted by rule 4123-17-40 of the Administrative code yields a negative number, the employer will incur no liability under this paragraph, but will not receive any refund for prior premiums paid except for those matters specifically addressed in paragraph (L)(2) of this rule. As used in this rule, "pure premium paid" means premiums actually paid under a base rating plan or an experience rating plan, and minimum premium paid under a retrospective rating plan. It does not include premiums billed for actual claims costs, including reserves at the end of ten years, under a retrospective rating plan. Obligations under a retrospective rating plan remain the responsibility of the employer regardless of the employer's status. The same principles shall apply to cases of a merger by a self-insuring employer and a state fund employer under the self-insurer's status. In addition, the provisions listed below shall apply:

1. Within thirty days of the receipt from the employer of the necessary forms and of a separate statement of assets and liabilities, the bureau will forward to the employer a letter stating the amount of liability (if any) due the state fund as outlined above and a copy of the computation of such liability (if any).
2. Within thirty days of the date of mailing of the letter by the bureau as outlined in paragraph (L)(1) of this rule, the employer shall reply by a letter, signed in handwriting, acknowledging that the employer agrees with the amount of liability specified in the letter and that there are no protests or claims hearings pending which could affect the amount of the liability. If any such matters are pending and would affect the liability, they must be detailed and set forth in the letter from the employer. This letter must also acknowledge that any protest letters, applications for handicap reimbursement or other requests affecting the risk's state fund experience filed subsequent to the date of this letter shall be considered invalid for both rebate of premium on state fund experience and the calculation of liability cited above. This letter must also specify the suggested effective date of the transfer to self-insurance which the employer requests, subject to paragraph (B) of this rule which requires that the effective date must be at least ninety days after the date the application forms are received by the bureau. Failure to comply with the requirements set forth herein shall terminate further consideration of the application.
3. Subsequent to the approval of the employer's self-insurance status and the effective date thereof by the administrator, the bureau shall issue a settlement sheet statement containing the adjustment required above and billing for an advance deposit as required by other rules of the commission. The employer shall pay the amounts required by this paragraph, pay the contribution to the self-insuring employers' guaranty fund under Section 4123.351 of the Revised Code, submit a performance surety bond or additional security, if required by the bureau, and estimated final payroll report as a state fund risk, all within thirty days of the date of the mailing of the administrator's executive order.
4. The final adjustments of all premiums due the state fund for the final payroll reports and final bureau audit

(if any), as well as the pending protests, etc., as specified in paragraph (L)(2) of this rule, shall all be settled and paid within six months from the date of transfer from state fund to self-insuring status. Employer's records must be made available promptly for final audit which must also be completed within six months from the date of the transfer from state risk to self-insurance.

M. If there is any change involving additions, mergers, or deletions of entities or ownership changes of a Self-Insuring employer, which would materially affect the administration of the employer's Self-Insuring program or the number of employees included in such program, the employer shall notify the bureau Self-Insuring Employers section within thirty days after the change occurs. Based upon the information provided or additional information requested by the bureau, the bureau will determine the effect of the change on the employer's Self-Insuring employer status, the adequacy of the employer's contribution to the self-insuring employers' guaranty fund, and the need for additional security.

4123-19-05 Where an employer is a Self-Insuring Risk and desires to become a State Risk
eff. 12/17/01

A. Where an employer is a Self-Insuring risk desires to become a State Risk, the employer transferring from a Self-Insuring risk to a State Risk shall be rated at the appropriate experience modifier to the employer's basic premium rate. Such a rate shall be determined pursuant to Section 4123.29 of the Revised Code.

B. The adjustment of the Self-Insurance premium of such employer shall be computed on an earned premium basis as of the date of transfer from Self-Insurance to the State Fund, which adjustment shall be controlled by the rules controlling the ordinary premium adjustment.

C. A Self-Insuring employer that transfers to the State Insurance Fund shall continue to administer Self-Insured claims for date of injury, disease or death during the period of Self-Insurance, and the employer shall be responsible to continue to pay compensation and benefits directly. Further, the employer shall remain obligated to pay to the bureau the Self-Insuring employer assessment calculated on the basis of the paid compensation for such claims attributable to the individual Self-Insuring employer according to provisions of Division I of Section 4123.35 of the Revised Code and a rule of the Bureau of Workers' Compensation adopted in accordance with Section 111.15 of the Revised Code.

4123-19-06 Procedures for revocation of self-insuring status
eff. 12/17/01

A. The bureau may direct that a public hearing be held on the question of revocation of a self-insuring employer's privilege of Self-Insurance if the employer that has elected with the approval of the bureau to pay compensation, etc., directly thereafter fails in any one of the following:
   1. Continued failure to file medical reports with the bureau or industrial commission or to submit reports to the injured worker required under law or rule;
   2. Continued failure to pay compensation or benefits in accordance with any law or bureau or commission rules in a timely manner;
   3. Failure to provide reasonable medical facilities;
   4. Continued failure to pay all costs of administration including fees of medical specialists to whom the commission or bureau refers claimants for physical examinations or refers claim files for review and opinion, or failure to pay claimant's travel expenses within thirty days as required by law or rule;
   5. Continued failure to keep a record of all injuries and occupational diseases resulting in more than seven days of temporary total disability or death or involving seven days or less of lost time where it appears that there will be permanent partial disability compensable under Division B of Section 4123.57 of the Revised Code, or where the employer denies the claim, and to report the same to the bureau and to furnish a copy of such report to the employee it concerns or to his surviving dependents;
   6. Continued failure to pay compensation within three weeks or benefits including failure to respond to a request for authorization to change physicians, approval of medical treatment, etc., within the period of thirty days after receipt of a physician's fee bill or request for any of the above mentioned benefits, unless the employer contests any of such matters, in which event the employer shall promptly notify the employee in writing and the bureau of such contest, along with the employer's notification to the employee that the employee has the right to request a hearing before the industrial commission;
   7. Failure to make its records and facilities available to employees of the bureau;
   8. Repeated failure to permit a claimant, his dependents or the representative of either, to review all of employer's medical records pertaining to the claim at all reasonable times and places within seventy-two hours of receiving a request;

9. Repeated failure to inform a claimant or his dependents and the Bureau of Workers' Compensation, in writing, as to what conditions it has recognized as related to his injury or occupational disease and what, if any, conditions it denies;
10. Harassing, dismissing or disciplining employees who have made complaints to the bureau;
11. Failure to pay contributions to the self-Insuring employer's guaranty fund as set forth in Section 4123.351 of the Revised Code; or
12. Repeated failure to comply strictly with any rule, regulation or order prescribed by the commission and bureau.

B. Should the bureau have reason to believe that the Self-Insuring employer has failed to comply with any of the matters listed in paragraph A of this rule involving the employer's financial strength or administrative ability to meet its obligations as a self-insuring employer, the bureau shall refer the matter for a public hearing on the question of revocation of the employer's privilege of self-Insurance. Such public hearing shall be conducted before the Self-Insured Review Panel in accordance with the provisions of Rule 4123-19-14 of the Administrative Code for issues involving the financial strength or the administrative ability of the employer to operate a self-insured workers' compensation program. The public hearing shall be conducted before the self-insuring employers evaluation board in accordance with the provisions of rule 4123-19-13 of the Administrative Code for issues involving unresolved complaints by injured workers or allegations of misconduct by the self-insuring employer.

C. The employer and its representative shall be notified in writing that such a public hearing will be held and shall be furnished with copies of any complaint of an employee or report from the employees of the bureau. For matters to be heard before the self-insured review panel, the bureau shall mail a notice of hearing to the employer and its representatives by regular mail, setting forth the date, time, and place of the hearing not less than twenty one days before such hearing. For matters to be heard before the self-insured employers evaluation board, the bureau shall mail a notice of the hearing to the claimant. The notice shall be mailed not less than fourteen days before such hearing.

D. At the hearing the testimony given shall be taken by a court reporter and copies of the transcript of such testimony shall be furnished to the self-insuring employer, the complaining claimant, their representatives, the Administrator and the members of the self-insured review panel or the self-insuring employers evaluation board.
   1. Should the self-insured review panel find that the self-Insuring employer has materially violated any parts of this rule or is incapable of operating a self-Insuring program, or refuses to conform to the rules and regulations of the industrial commission and bureau, then the administrator will forthwith issue a revocation of authority to pay compensation, etc., directly.
   2. Should the self-insuring employers evaluation board recommend to the administrator that an employer's privilege of self-insurance be revoked, the administrator shall promptly and fully implement such recommendation without further hearing.
   3. An employer that has been revoked pursuant to paragraph (D)(1) or (D)(2) of this rule shall be required to pay forthwith its eight months' advance estimated premium into the state insurance fund.

E. The bureau may, at its discretion and after proper hearing, revoke the Self-Insuring status of a unit of a parent company when the evidence presented at the hearing clearly shows that the unit is operating at a different location from the parent company, and its actions causing the revocation were not directed nor authorized by the parent company.

4123-19-07 Rules controlling renewals of State Risks
eff. 12/14/92

A. One week prior to the date of expiration of insurance of each private risk the bureau shall mail to each such risk, a "Payroll Report" Form.

B. The employer shall, within one month from the date of expiration of his last six months' insurance period, complete and return the payroll report to the bureau with premium remittance.

C. If, within two months immediately after the expiration of the six months' period, an employer fails to file a report of the employer's actual payroll expenditures for the period, the premium found to be due from such employer for the period shall be increased in an amount equal to one percent , the increase, however, not to be less than three dollars nor more than fifteen dollars.
   1. The premium determined by the bureau to be due from an employer shall be payable on or before the end of the coverage period established by the premium security deposit, or within the time specified by the bureau if the period for which the advance premium has been paid is less than eight months. If an employer fails to pay such premium when due, there shall be added to such premium an amount equal to three percent of

such premium. If the failure to pay continues for more than one month, the premium shall be further increased in an amount equal to two percent of such premium for each additional month or part of a month, but the total of all such additional amounts shall not exceed twelve percent of such premium. However, if the employer files an appropriate payroll report within the time provided by law or within the time specified by the bureau if the period for which he has paid an estimated premium is less than eight months, the employer shall not be in default and these provisions will not apply if the employer pays such premium within fifteen days after he has been first notified by the bureau of the amount due.

2. Any deficiencies in amounts of premium security deposit paid by an employer for any period or periods shall be subject to an interest charge of six percent per annum from the respective dates of the notice by the bureau to the employer of such deficiency in the premium security deposit. In determining the interest due on deficiencies in premium security deposit payments, a charge in each case shall be made against the employer in a sum equal to interest at the rate of six percent per annum of the premium security deposit due but remaining unpaid sixty days after notice by the bureau.
3. Any interest charges or penalties provided for in paragraphs (C)(1) and (C)(2) of this rule and paid, shall be credited to the employer's account for rating purposes in the same manner as premium.
4. The amount of premium due from such employer may be certified to the Attorney General for collection.

D. The question of classification or rating shall not be permitted to operate so as to delay the making of premium payment.

E. When the risk has paid its adjustments and renewal premium to the Bureau, the Bureau shall forthwith mail to such a risk a "Certificate of Premium Payment" which certificate shall set forth the renewal, effective and expiration dates of coverage for the risk.

F. For counties and public employer taxing districts, payment of premium is due in accordance with the schedule established under Division (B) of Section 4123.41 of the Revised Code. Where such employer fails to pay at least forty-five per cent of the premium due by May fifteenth or the full premium due by September first, the bureau may impose an interest penalty for late payment for any amount due for each month or part of a month past due as scheduled at the interest rate established by the state tax commissioner pursuant to Section 5703.47 of the Revised Code.

4123-19-08 Renewal of Self-Insuring Risks
eff. 12/17/01

A. The privilege of an employer to pay compensation, etc., directly, must be renewed annually. Beginning with the effective date of this rule, prior to renewal of the employer's privilege of Self-Insurance, the bureau shall re-evaluate the employer's financial strength and administrative ability as described in Rule 4123-19-03 of the Administrative Code. The bureau will consider past performance of the self-insuring employer as an additional factor in determining whether to renew the privilege of Self-Insurance. The five-hundred employee requirement in division (B)(1) of section 4123.35 of the Revised Code will not be considered mandatory in the case of an employer seeking to renew its privilege of Self-Insurance. Waivers granted for good cause by the Administrator pursuant to paragraph (H) of Rule 4123-19-03 of the Administrative Code will continue in effect indefinitely unless there is a significant change, in the opinion of the Bureau of Workers' Compensation.

B. Self-insuring risks desiring to continue paying compensation, etc., directly, shall secure from the bureau a copy of the appropriate form of application which shall be completed and returned to the bureau. The employer shall include with the renewal application a recording of the number of lost time claims. The employer may also be required to include a reporting of the amount of payments made and the amount of reserves established for the aforementioned claims as sufficient to cover future liabilities. The properly completed renewal forms shall be signed by the Ohio self-insuring program administrator who has been designated by the employer to the bureau or an officer of the company and filed ninety days prior to renewal date.

C. The application forms and the employer's financial statement shall be reviewed by the bureau. In order to renew its status as a self-insuring employer, the employer shall establish the following to the bureau's satisfaction: that the employer has fulfilled the minimal level of performance standards that an employer is required to meet before being granted permission to pay compensation and benefits directly , as provided in paragraph (K) of rule 4123-19-03 of the Administrative Code; that the employer has substantially resolved all outstanding complaints filed with the bureau; and that the employer has achieved a satisfactory rating in its most recent audit report. Upon compliance with these requirements, the Administrator may approve the renewal application. If the application is granted, the bureau will so notify the applicant within thirty days prior to the renewal date. In this notification the bureau shall specify the contribution to the self-insuring employers' guaranty fund and the amount of the

additional security, if required.

D. If the aforesaid employer, upon receipt of such notification, promptly provides the bureau with the security in the amount and form specified by the bureau, the bureau thereafter will issue said employer a revised "Findings of Facts" statement and certificate which will be sent to the risk by the bureau.

E. In the event the bureau finds that the minimum criteria set forth in the rules have not been met, the bureau shall give written notice to the applicant that the privilege to pay compensation, etc., directly, will not be renewed. Said notice shall give the employer two weeks to exercise the right to a public hearing before the administrator, or the self-insured review panel, in accordance with the provisions of rule 4123-19-14 of the Administrative Code. If no hearing is requested or if the Administrator or self-insured review panel upholds the non-renewal, the applicant shall forthwith be required to pay its full premium for the intervening period from the date of the expiration of the last renewal date to the date of the administrator's or self-insured review panel's order of non-renewal into the State Insurance Fund or to obtain a binder for state fund coverage as of the expiration date of its last renewal.

F. If, for any reason, the Self-Insuring Risk is not renewed and said risk does not pay its premium security deposit for the ensuing period into the State Insurance Fund or obtain a binder for State Fund coverage as of the expiration date of its last renewal, said risk shall be deemed an amenable but noncomplying employer pursuant to Sections 4123.01 to 4123.99 of the Revised Code.

G. If, for any reason, it is not possible to finally pass on the employer's application for renewal prior to the expiration of its present authorization, an extension may be granted until such time as the final disposition of the application for renewal can be made.

4123-19-09 In regard to complaints filed by employees against Self-Insuring employers under the provisions of Section 4123.35 of the Revised Code
eff. 12/17/01

A. The bureau shall receive all complaints concerning any employer engaged in paying compensation directly to its employees. The bureau shall transfer to the Self-Insuring Employers Evaluation Board only those complaints which are not resolved. An employer shall respond in writing to a complaint within thirty days of receipt thereof, and such response shall be made a part of the complaint file.

B. The Administrator of the Bureau of Workers' Compensation shall investigate and process all complaints against a self-insuring employer through the self-insuring employers section of the bureau. However, the bureau may dismiss a complaint based upon the employer's action or lack of action with respect to events that occurred more than two years prior to the filing of the complaint, unless the facts could not have been reasonably known to the claimant.

C. The bureau shall maintain a file by employers of all complaints that relate to the employer, together with any information filed by the employer as to such complaints. A copy of all complaints shall become a part of the Self-Insuring employer's record file and shall be available at the time of renewal consideration. The bureau shall evaluate each complaint and take appropriate action as follows:
   1. If the bureau records for such employee does not contain full information as to the matter which is the subject of the complaint, the bureau may attempt to obtain such information by correspondence with the Self-Insuring employer, the claimant, and their authorized representatives, if any.
   2. The bureau may also audit the program of the employer in the manner provided in Section 4123.35 of the Revised Code.

D. Following receipt of all necessary information including bureau records, correspondence from the employee and the employer, or an audit by the Bureau of Workers' Compensation, the bureau may dismiss the complaint as invalid or find that the complaint has been resolved. Any unresolved complaint against a self-Insuring employer shall be referred to the self-insuring employers evaluation board for further action in accordance with the provisions of rule 4123-19-13 of the Administrative Code. If the bureau determines that a complaint is invalid or resolved and decides not to present the complaint to the self-insuring employers evaluation board, the claimant may request that the complaint be presented to the administrator or the self-insuring employer's evaluation board for further consideration.

E. Complaints referred to the bureau as provided above shall be retained in the employer's file for the period of four years from the date of resolution.

F. No employer that elects to pay compensation directly shall harass, dismiss or otherwise discipline any employee for making a complaint. Upon receipt of this information that such harassment, dismissal or other disciplinary action has been taken, the bureau shall assign the matter for hearing pursuant to the provisions of rule 4123-19-13 of the Administrative Code before the members of the self-insuring employers evaluation board. If the Board finds that such employer is guilty of harassing, dismissing or otherwise disciplining the claimant for making the complaint, the Board shall levy a reasonable financial penalty under the circumstances as the Board deems appropriate, payable by the employer to the Surplus Fund.

G. Repeated violations of this rule shall be grounds for revocation of the employer's privilege to pay compensation, etc., directly.

4123-19-10 In regard to audits by the Bureau of Workers' Compensation
eff. 12/17/01

A. The Bureau of Workers' Compensation shall audit the programs of employers who elect to pay compensation directly in the following situations:
   1. Audit shall be conducted by the bureau on a random basis.
   2. In addition, the bureau shall make such audits whenever the bureau has grounds for believing that an employer is not in full compliance with the rules of the commission or the provisions of Chapter 4123. of the Revised Code.
   3. Upon request from the self-insured review panel or the self-insuring employers evaluation board.
B. Such audits shall include the employer's methods of furnishing medical, surgical, nursing and hospital attention services, medicines and funeral expenses; the employer's payment of compensation or benefits to claimants and dependents and whether this is being done in a proper and timely manner; whether the employer has promptly filed all reports required under the rules of the commission and the bureau and the provisions of Chapter 4123. of the Revised Code. Such audits may also be used to evaluate whether the employer is providing medical examinations and evaluations in a timely manner; and whether the employer has harassed, dismissed or otherwise disciplined employees who have filed complaints against such employer with the Bureau of Workers' Compensation.
C. The bureau shall report its findings on such audits to the employer and the Self-Insuring Employers Evaluation Board, where the Board had requested the audit, and shall evaluate such findings and take such action as is indicated.

4123-19-11 Fixing time limits beyond which the failure of a Self-Insuring employer to provide for the
eff. 12/17/01 **necessary medical examinations and evaluations may not delay a decision on a claim**

A. When a self-insuring employer has provided or arranged for a necessary medical examination or evaluation, in accordance with paragraph (B) of Rule 4121-03-09 of the Administrative Code it shall promptly notify the commission that it has done so.
B. Failure of a Self-Insuring employer to provide for or arrange for the scheduling of such necessary medical examinations and evaluations within the period of fifteen days from the notification shall not delay a decision in claim.

4123-19-12 Grounds for holding public hearings to evaluate the program for Self-Insuring employers
eff. 05/09/90

The Administrator of the Bureau of Workers' Compensation shall hold a public hearing to evaluate the program for Self-Insuring employers in the following situations:
A. If there has been a substantial amendment of the statutes relating to Self-Insuring employers.
B. If decisions are rendered by the Supreme Court of Ohio which materially change the interpretation of such statutes or invalidate material portions of the Rules of the Industrial Commission or the Bureau of Workers' Compensation.
C. If there is substantial evidence that the Self-Insuring employers are not complying with the law of the State of Ohio, the rules and procedures of the Bureau of Workers' Compensation and the Industrial Commission.

4123-19-13 Self-Insuring Employers Evaluation Board
eff. 12/17/01

A. Section 4123.352 of the Revised Code establishes a Self-Insuring Employers Evaluation Board. The Board shall consist of three members:
   1. The member of the Industrial Commission representing the public shall serve , ex officio, as Chairman.
   2. A member of the "Ohio Self-Insurers Association" shall be appointed by the Governor with the advice and consent of the Senate.
   3. A member of labor shall be appointed by the Governor with the advice and consent of the Senate.
   4. Not more than two of the members shall be of the same party.
   5. For purposes of administration, the Board shall be part of the bureau. The bureau shall furnish the necessary

office space, staff and supplies. The Board shall meet as the Board determines or as requested by the Bureau of Workers' Compensation.

B. All unresolved complaints or allegations of misconduct against a self-insuring employer shall be referred to the board by the bureau. At the claimant's request, the board may elect to hear a complaint that had been dismissed by the bureau.
   1. The Board shall investigate and may order the employer to take corrective action in accordance with such schedule as the Board fixes.
   2. A Board determination need not be made by formal hearing but must be issued in written form and contain the signatures of at least two members.
   3. If after a hearing pursuant to Chapter 119. of the Revised Code and Rules of the Industrial Commission and Bureau of Workers' Compensation, the Board determines an employer has failed to correct deficiencies within the time fixed by the Board, or is otherwise violating Chapter 4123. of the Revised Code or the Rules of the Industrial Commission or the Bureau of Workers' Compensation, the Board shall recommend to the Administrator:
      a. Revocation of employer's privilege of Self-Insurance;
      b. Probation;
      c. A civil penalty not to exceed ten thousand dollars for each violation of the law or rules, payable into the self-insuring surety fund ; or
      d. Any other appropriate penalty.
   4. A board recommendation to revoke an employer's privilege of self-insurance must be by unanimous vote.
   5. A penalty other than revocation shall be by majority vote of the board and will be the responsibility of the bureau to monitor for compliance.
   6. The bureau shall promptly and fully implement recommendations from the Board for disciplining a self-insuring employer.

4123-19-14 Self-Insured Review Panel
eff. 12/17/01

A. The Administrator of the Bureau of Workers' Compensation may delegate the authority granted to the Administrator under Chapters 4121. and 4123. of the Revised Code for determining self-insuring employer matters as may be authorized. For this purpose, the Administrator may appoint a self-insured review panel to provide advice to the Administrator and the bureau's self-insured department and provide employers with hearings on matters referred to the panel, or as requested by the employer. The bureau shall refer all unresolved issues involving the financial strength or the administrative ability of the employer to operate a self-insured workers' compensation program to the panel for a hearing.

B. The self-insured review panel shall consist of three members appointed by the Administrator. The members shall consist of persons who shall have expertise or experience in matters relating to Self-Insuring employers.

C. The self-insured review panel shall hold meetings and hearings to determine matters referred to it by the administrator or the bureau's self-insured department for a review. The panel may issue decisions without formal hearing, and may advise the administrator or the self-insured department on issues referred to it. The panel shall afford an employer the opportunity for a formal hearing before the panel upon request.

D. If an employer requests a hearing before the review panel or the panel determines that a hearing is in the best interest of the employer or the State Insurance Fund, the panel shall mail a notice of hearing to the employer and its representatives by regular mail, setting forth the date, time and place of the hearing. The notice shall be mailed not less than twenty one days before the date of such hearing. In justifiable cases, an emergency hearing may be arranged with the Review Panel.

E. The panel shall keep a record of its dockets and proceedings, The panel's decisions shall be reduced to writing and mailed to all interested parties and shall state the evidence upon which the decision was based and the reasons for the panel's actions. The decision of the panel shall be the decision of the Administrator. If the employer files a written appeal within fourteen days of the employer's receipt of the panel's decision, at the Administrator's discretion, the Administrator may reconsider the decision of the panel, and may conduct a formal hearing for such purpose.

F. The Administrator may authorize the review panel to consider the following matters:
   1. Granting or denying an application for the privilege to pay compensation, etc., directly;
   2. Non-renewals of self-insured status;
   3. Revocation of self-insuring employers status;
   4. Issues of a self-insuring employer's adequacy of contribution to the self-insuring employers' guaranty fund or need for additional security under Section 4123.351 of the Revised Code;

5. Any other self-insuring employer matter as authorized and delegated by the Administrator under Chapters 4121. and 4123. of the Revised Code.

4123-19-15 Assessment for Self-Insuring Employers' Guaranty Fund
eff. 12/17/01

A. The Bureau of Workers' Compensation shall require self-insuring employers to pay contribution to the self-insuring employers' guaranty fund as provided in this rule. The contributions due from self-insuring employers shall be established at rates as low as possible but such as will ensure sufficient monies to guarantee the payment of any claims against the fund. All self-insuring employers who are paying compensation as defined by division L of section 4123.35 of the Revised Code, whether active or inactive as a self-insuring employer, are required to pay a contribution to the self-insuring employers' guaranty fund as provided in this rule.

B. The bureau shall maintain a minimum balance of funds in the self-insuring employers' guaranty fund of two times the prior year's payments from the fund as determined at the end of each calendar year to ensure sufficient monies to guarantee the payment of any claims against the fund. When the bureau determines that there are insufficient funds in the guaranty fund and an assessment is necessary to ensure the minimum balance in the fund, the bureau shall assess all self-insuring employers an annual contribution as determined by the administrator to maintain the minimum balance. Annual contributions will not be assessed to all self-insuring employers when the bureau determines that the fund exceeds the minimum amount necessary to guarantee the payment of any claims against the fund, except as provided in paragraph C of this rule.

C. In addition to any contribution required of all self-insuring employers as provided in paragraph B of this rule, the contribution to the self-insuring employers' guaranty fund shall be as follows:

1. New self-insuring employers, for each of the first three years of self-insurance, shall be assessed six per cent of base rate premium as reported on the total of the last two full six-month semi-annual payroll reports submitted as a subscriber to the state insurance fund.

2. A self-insuring employer identified as a high risk employer by the bureau shall be assessed six per cent of the previous year's paid compensation as reported to the bureau.

The assessment shall not be less than $5,000 for any twelve-month period of coverage. All annual premiums to the self-insuring employers' guaranty fund are due and shall be collected within forty-five days from the receipt of the bureau's invoice. Self-insuring employers not making timely payments shall be subject to revocation of self-insuring employer status.

D. As used in this rule, the bureau shall determine whether a self-insuring employer is a "high risk" employer based upon a review of the self-insuring employer's certified financial records submitted with the application for self-insuring employer renewal. The bureau's analysis and determination may include, but is not limited to, a review of the self-insuring employer's equity to debt ratio, return on equity, Z-score, and a Moody's rating, or other nationally recognized financial rating of the long term stability of a company.

4123-19-16 Self-Insured Construction Projects
eff. 12/15/98

A. As used in this rule:

1. “Responsible self-insured employer” or “responsible employer” means the self-insuring employer that enters into a construction contract and applies for permission to self-insure the construction contract. The responsible employer is the entity responsible for the cost of the construction project and generally will be the owner of the project. The responsible employer is the payor under the contract. “Responsible self-insured employer” or “responsible employer” may include a self-insured general contractor or construction manager whose principal source of business is the execution of construction projects.
2. “General contractor” means a self-insured employer that has entered into a contract with an owner to perform more than fifty per cent, by value, of the work on a construction project.
3. “Construction manager” means a self-insured employer that has entered into a contract with an owner to provide substantially the same services described in division (a) of section 9.33 of the Revised Code in connection with a construction project. Regardless of any contrary terms of section 9.33 of the Revised Code, for purposes of this rule, the term “construction manager” is not limited to public projects and may apply even if the construction manager also performs construction work on the project.
4. “Contracting employer” or “subcontracting employer” means any employer, whether state fund or self-insured, that has contracted either directly with a responsible self-insuring employer or with a contracting or subcontracting employer to perform construction services on the construction project. The contracting

employer is the payee under the contract, except for where the contracting employer has subcontracted with another contracting employer.

B. The purpose of this rule is to establish standards by which the administrator may permit a responsible self-insuring employer to self-insure a construction project entered into by the responsible self-insuring employer pursuant to division (O) of section 4123.35 of the Revised Code.

C. The administrator's authority to grant self-insured status for a construction project is permissive. The bureau of workers' compensation may establish criteria for granting self-insured status to ensure the financial stability and claims continuity of the workers' compensation program. The burden of proof is on the responsible self-insured employer to satisfy the requirements of division (O) of section 4123.35 of the Revised Code and such other requirements as the administrator may establish by this rule or other policy for granting permission to self-insure a construction project.

D. A responsible employer filing an application to self-insure a construction project shall be a self-insuring employer under the Ohio workers' compensation statutes.

E. In order for a responsible employer to be considered for self-insurance under division (O) of section 4123.35 of the Revised Code, the responsible employer must submit an application including, but not limited to, the following information:

1. Dates the construction project is scheduled to begin and end;
2. The estimated cost of the project;
3. The contracting and subcontracting employers whose employees are to be self-insured by the responsible employer;
4. The provisions of a safety program specifically designed for the project;
5. A statement as to whether a collective bargaining agreement governing the rights, duties, and obligations of each of the parties to the agreement with respect to the project exists between the self-insuring employer and a labor organization.

The administrator may require other information as needed to aid in the decision-making process.

F. If the administrator approves the application, the administrator shall mail to the responsible self-insured employer a certificate granting the privilege to self-insure the construction project. Upon approval, the responsible employer is responsible for the administration and payment of all claims under chapters 4121. and 4123. of the Revised Code for the employees of any contracting employers and subcontracting employers covered under the certificate who receive injuries or are killed in the course of and arising out of employment on the project, or who contract an occupational disease in the course of employment on the project.

G. The responsible employer is entitled to all of the protections provided under chapters 4121. and 4123. of the Revised Code with respect to the employees of the contracting and subcontracting employers covered under the certificate as if the employees were employees of the responsible employer.

H. The contracting and subcontracting employers included under the certificate are entitled to the protections provided under chapters 4121. and 4123. of the Revised Code with respect to the contracting and subcontracting employer's employees who are employed on the construction project which is the subject of the certificate.

I. The contracting and subcontracting employers included under the certificate shall identify in their payroll records the employees who are considered the employees of the responsible employer listed in that certificate for purposes of chapters 4121. and 4123. of the Revised Code, and the amount that those employees earned from employment on the project that is subject to the certificate. The administrator shall exclude the payroll reported when determining those contracting or subcontracting employers' premiums or assessments required under chapters 4121. and 4123. of the Revised Code.

J. The responsible employer shall include in the amount of paid compensation it reports pursuant to division (L) of section 4123.35 of the Revised Code, the amount of paid compensation that the responsible employer paid pursuant to division (O) of section 4123.35 of the Revised Code.

PREMIUM RATE-MAKING

The State Insurance Fund is a self-supporting, non-profit organization established by the legislature and administered by the Industrial Commission and Bureau of Workers' Compensation. The law provides premiums collected be expensed only for payment of compensation and medical costs for victims of industrial accidents and diseases, with the following exception: an amount not to exceed one percent of contributions paid by employers shall be allocated to the Division of Safety and Hygiene for investigation and prevention of industrial accidents and diseases. Until required for payment of benefits, premiums may be invested. Investment income thus earned may be expensed only for payment of compensation and medical benefits. Operational costs of the Industrial Commission and the Bureau of Workers' Compensation are defrayed by a separate administrative assessment paid by employers.

The bureau has the obligation to collect a sufficient amount of money in each year to pay the ultimate cost of all injuries occurring during that year. Some of the injured workers will receive compensation for many years. Thus, the rate-making process is necessarily complicated, because there is no simple way to predict future costs of injuries. Rate-making is accomplished by taking the experience of the past and projecting it into the future.

The Ohio Workers' Compensation system is founded upon the insurance principle of shared liability. As a first step toward developing a system of equitable sharing of liability, Section 35 of Article II of the Constitution requires that industries be classified according to hazard. The more hazardous industries produce more accidents and higher costs. Approximately 540 classifications of hazard have been established, and into each of these classifications are placed employers who have a similar degree of hazard in their operations. (An employer will be assigned more than one manual number if its operations so require.) Naturally, such comparisons cannot be made with mathematical certainty, and this fact, together with the constantly changing methods of operation, makes necessary the periodic review of assignments of employers into the various classifications. For convenience, each classification is assigned a manual number. This number, together with the policy number that identifies the employer, appears on all orders to pay benefits to facilitate charging the cost to the proper employer and proper classification.

Having established the classifications, and having assigned all employers to their proper classifications, the bureau must determine a method for assessing costs against those employers in each classification. The size of employers is highly varied and it is obvious that an employer having 1,000 employees is more likely to have accidents than is an employer in a similar industry having only three employees. Therefore, payroll is used as the measure of exposure to industrial accidents. Once a rate for premium contributions has been established, it is applied to payrolls of the employers in a specific classification so that the larger employer will pay the larger share of the total risk. While this does not result in perfect equality - because pay rates are not always equal in comparable jobs, and each employer follows his or her own method of job distribution - payroll is the best available measure of exposure.

Under the Ohio Workers' Compensation system, each classification "determines" its own rate. The total losses of each classification, when compared to the total payroll of the classification, produce the rate of contribution from the employers within that classification. There are some costs, fortuitous in nature, such as catastrophe loss, that are not related to the normal hazard of the industry. These losses are spread over all of the classifications of an industry group. However, as these losses make up only a small percentage of the total losses, they are not sufficient to distort significantly the principle that each classification "makes" its own rate.

In constructing the base rate for a particular classification, the bureau begins with actual awards of compensation and medical benefits made to injured workers of employers within that classification, on claims with injury dates during the oldest four of the last five calendar injury years, measured from December 31 of the year preceding the effective date of the rate (experience period) as specified in Section 4123.34, Ohio Revised Code. For rates effective July 1, 2000, the bureau uses awards made on claims involving injury dates from 1995 through 1998. For the July 1, 2001, rating period, the oldest injury year (1995) will drop out of the experience, and a new injury year (1999) will be added, affecting the experience for the first time.

Reserves are added to awards. Claims falling within the experience period are examined, as of the cut-off date (established annually) for that year in which rates are made, and reserves are established, based upon claims data. A reserve is a prediction of the portion of the cost of a claim to be paid in the future. (The other portion of the cost is the compensation and medical paid to a specific date of those claims.) Placement of a reserve on an existing claim sometimes gives rise to the erroneous impression that the bureau is trying to collect more money to pay that claim. Quite to the contrary, the premium that will be used to pay that claim was collected during the year in which the claim was incurred. The reserve is used in the calculation to establish future premium needs only, which are in turn used to pay the cost of future claims.

This definition of a reserve can be stated in another manner, which defines its relationship to the claim to which it has been assigned. A reserve is a prediction of the total future cost of claims of a similar nature (same reserve code). Thus, by assigning a reserve of $10,000 to the claims identified by Reserve Code A, we are saying that on the average a Code A claim will result in $10,000 additional compensation, medical, and/or death benefits being paid until the

claim is finally closed. In calculating reserve amounts, the compensation and the medical benefits on all claims in that category are used. The claim in which only a small amount of compensation is awarded is included in the average, just as is the claim containing an extraordinary amount of compensation. While the application of a reserve may be difficult to understand on an individual claim basis, it must be realized that the reserve is based upon average costs of claims that are of similar nature.

From a strict, actuarial point of view, there is no justification for removal or reduction of a reserve (in essence removal of the claim from the particular grouping code in which it has been placed) except for an error in assignment. Any deviations from this policy, including reductions in the amount of a valid reserve, are concessions in consideration of extenuating circumstances involving a particular claim. The reserve is in existence only during the rate-making process. When that is finished, the slate is wiped clean, and the process is repeated during calculation of rates the following year.

The combination of awards and reserves is known as raw losses. However, raw losses do not present the total cost picture. Many claims apparently dormant at survey date will be reopened, and the costs of reopening must be considered. In addition some injuries have occurred within the experience period for which claims have not yet been filed, as a two-year statute of limitation exists in the filing of claims. Thus, development factors based upon past experience must be applied to the raw losses to provide for these additional costs. Application of the development factors to raw losses yields developed losses. The next step in constructing base rates is to apply changes in the compensation benefit levels. The rates of premium being calculated must produce money to cover losses that will be paid at the new and higher level. Some of the losses in the experience period were paid at a lower benefit level so they must be adjusted as though they were paid at the new level. Increases in medical costs must be taken into account as well as changes in wage level. Application of these adjustments to development losses yields rate losses. Another factor is then introduced in to the calculation of the manual rate to prevent violent rate fluctuations in that classification. This factor, credibility, is a measure that separates random occurrences from true expectations. In manual classifications with large amounts of payroll and losses, the total future losses can be predicted from past loss experience with a high degree of accuracy. Thus, these classifications are assigned a high credibility. At the same time, any given loss has a greater effect, rate-wise, on a small classification than it does on a larger one. To moderate the effect of these losses, classifications are assigned credibility of decreasing magnitude as the classification data base becomes smaller.

In addition, there may be more credits than penalties, or vice versa, in the experience rating system when it is applied to the experience rated employers within the classification. When this occurs, there is an off-balance, and a factor must be applied to the classification to offset the off-balance condition. This off-balance, or excess of credit or penalty in any given classification, is limited to that classification.

Adjustment of the calculated rate by classification credibility, the off-balance factor, the factor for maintenance of the Division of Safety and Hygiene (cited previously), the factor for the Premium Payment Security Fund, the catastrophe factor and the limit for the maximum change produces the basic rate. This is the rate paid by every non-experience rated risk.

Limitations have been placed upon the percentages of change in basic rates from one year to the next. Under those limits a classification’s basic rate has not been permitted to increase or decrease by more than 30 percent from the previous year’s basic rate.

The pure insurance principle of sharing liability, as reflected in the basic rate, does not reward or penalize individual employers. Experience rating is a departure from the pure insurance concept of sharing liability. It is an incentive system designed to promote safety practices. An employer who has a better than average loss experience receives a credit against the basic rate for its classification, and conversely, an employer who has a bad loss experience is penalized and has to pay a rate higher than the basic rate. Section 4123.34, Ohio Revised Code, provides that the Workers' Compensation Oversight Commission shall employ that system of experience rating best calculated to rate the individual risk most equitably while preserving the basic principle of workers’ compensation insurance. Experience rating is a compromise between self-insurance and the pure insurance principle involved with the basic rate. While it can never relieve an employer who has no accidents from paying premium, it can reduce an employer's premium compared with fellow employers within the same classification. To the cost-conscious employer, this is an important factor.

Not all employers are experience rated; only those who meet the prerequisites as outlined in Rule 4123-17-03 are eligible. Those who do not qualify for experience rating are excluded for their own benefit. Were smaller employers experience rated, their rates could fluctuate severely with the occurrence of a single serious accident, and the stability of premium expense that is essential to their economic well-being would be disrupted. In other words a single chance accident - one not expected for the small employer - could result in a severe penalty rating for four years.

Rate Definitions

NCCI Base Rate: This is the rate that employers, who are **not** experience rated, pay as a percentage of their payroll according to rule 4123-17-06 (See page 29 of this manual). The NCCI classification base rates can be found on pages 117 through 120 of this manual. These rates are used to calculate the premium for a base rated employer.

Modified Rate: This is the rate that employers, who **are** experience rated, pay as a percentage of their payroll. This rate is calculated by taking the base rate and multiplying it by the employer's experience modification (EM) factor. This method is used to calculate the premium for an experience rated employer.

Blended Rate: This is the rate that employers will see on their payroll reports. It consists of the base rate or modified rate, the administrative cost (AC) assessment, and the Disabled Workers Relief Fund (DWRF) and DWRF2 assessments.

How Assessments Are Calculated

Administrative Cost (AC) Assessment: This is calculated by multiplying the AC rate by the base rated premium for base rated employers or the modified rate premium for experience rated employers. The rate can be found on page 112 of this manual.

Disabled Workers Relief Fund (DWRF) Assessment: This is calculated by multiplying the DWRF rate by the payroll for base rated or experience rated employers. The rate can be found on page 112 of this manual.

Disabled Workers Relief Fund 2 (DWRF2) Assessment: This is calculated by multiplying the DWRF2 rate by the base rated premium for base rated employers and for experience rated employers. The rate can be found on page 112 of this manual.

APPENDIX A
TABLE 1
Part A

Credibility and Maximum Value of a Loss

Credibility Group	Expected Losses*	Credibility Percent	Group Maximum Value
1	8,000	05	12,500
2	15,000	10	12,500
3	27,000	15	25,000
4	45,000	20	37,500
5	62,500	25	55,000
6	90,000	30	75,000
7	122,500	35	87,500
8	160,000	40	100,000
9	202,500	45	112,500
10	250,000	50	125,000
11	302,500	55	137,500
12	360,000	60	150,000
13	422,500	65	162,500
14	490,000	70	175,000
15	562,500	75	187,500
16	640,000	80	200,000
17	722,500	85	212,500
18	810,000	90	225,000
19	902,500	95	237,500
20	1,000,000	100	250,000

Catastrophe value equals $250,000
*Expected losses are lower limits of credibility groups
Revised 7-1-2002

APPENDIX B
TABLE 1
Part B-2

Industry Group	NCCI Manual Classifications
1	**AGRICULTURE:** 0005, 0008, 0016, 0034, 0035, 0036, 0037, 0079, 0083, 0113, 0170, 0251, 2702
2	**EXTRACTION:** 1005, 1016, 1164, 1165, 1320, 1430, 1438, 1452, 1624, 1654, 1655, 1710, 4000
3	**MANUFACTURING:** 1463, 1472, 1642, 1699, 1701, 1741, 1747, 1748, 1803, 1852, 1853, 1860, 1924, 1925, 2001, 2002, 2003, 2014, 2016, 2021, 2039, 2041, 2065, 2070, 2081, 2089, 2095, 2110, 2111, 2112, 2114, 2121, 2130, 2143, 2150, 2172, 2174, 2211, 2220, 2286, 2288, 2300, 2302, 2305, 2361, 2362, 2380, 2386, 2388, 2402, 2413, 2416, 2417, 2501, 2503, 2534, 2570, 2576, 2578, 2600, 2623, 2651, 2660, 2670, 2683, 2688, 2710, 2714, 2731, 2735, 2759, 2790, 2802, 2812, 2835, 2836, 2841, 2881, 2883, 2913, 2915, 2916, 2923, 2942, 2960, 3004, 3018, 3022, 3027, 3028, 3030, 3040, 3041, 3042, 3064, 3066, 3076, 3081, 3082, 3085, 3110, 3111, 3113, 3114, 3118, 3119, 3122, 3126, 3131, 3132, 3145, 3146, 3169, 3175, 3179, 3180, 3188, 3220, 3223, 3224, 3227, 3240, 3241, 3255, 3257, 3270, 3300, 3303, 3307, 3315, 3334, 3336, 3372, 3373, 3383, 3385, 3400, 3507, 3515, 3548, 3559, 3574, 3581, 3612, 3620, 3629, 3632, 3634, 3635, 3638, 3642, 3643, 3647, 3648, 3681, 3685, 3803, 3807, 3808, 3821, 3822, 3824, 3826, 3827, 3830, 3851, 3865, 3881, 4021, 4024, 4034, 4036, 4038, 4053, 4061, 4062, 4101, 4111, 4112, 4113, 4114, 4130, 4131, 4133, 4150, 4206, 4207, 4239, 4240, 4243, 4244, 4250, 4251, 4263, 4273, 4279, 4282, 4283, 4299, 4304, 4307, 4308, 4351, 4352, 4360, 4410, 4420, 4431, 4432, 4439, 4452, 4459, 4470, 4484, 4493, 4557, 4558, 4561, 4568, 4581, 4583, 4611, 4635, 4653, 4665, 4670, 4683, 4686, 4692, 4693, 4703, 4717, 4720, 4740, 4741, 4751, 4771, 4825, 4828, 4829, 4902, 4923, 5951, 6504, 6811, 6834, 6854, 6882, 6884, 9501, 9505, 9522
4	**CONSTRUCTION:** 0042, 0050, 0106, 1322, 3365, 3719, 3724, 3726, 5020, 5022, 5037, 5040, 5057, 5059, 5069, 5102, 5146, 5160, 5183, 5188, 5190, 5213, 5215, 5221, 5222, 5223, 5348, 5402, 5403, 5437, 5443, 5445, 5462, 5472, 5473, 5474, 5478, 5479, 5480, 5491, 5506, 5507, 5508, 5536, 5537, 5538, 5551, 5605, 5606, 5610, 5645, 5651, 5703, 5705, 6003, 6005, 6017, 6018, 6045, 6204, 6206, 6213, 6214, 6216, 6217, 6229, 6233, 6235, 6236, 6237, 6251, 6252, 6260, 6306, 6319, 6325, 6400, 7538, 7601, 7605, 7611, 7612, 7613, 7855, 8227, 9534, 9554
5	**TRANSPORTATION:** 6704, 7133, 7219, 7222, 7228, 7229, 7230, 7231, 7232, 7370, 7380, 7382, 7403, 7405, 7409, 7420, 7421, 7422, 7423, 7425, 7431, 8385
6	**UTILITY:** 7502, 7515, 7520, 7539, 7540, 7580, 7600, 8901
7	**COMMERCIAL:** 0400, 0401, 2105, 2131, 2156, 2157, 4361, 7390, 8001, 8002, 8006, 8008, 8010, 8013, 8015, 8017, 8018, 8021, 8031, 8032, 8033, 8039, 8044, 8045, 8046, 8047, 8050, 8058, 8072, 8102, 8103, 8105, 8106, 8107, 8111, 8116, 8203, 8204, 8209, 8215, 8232, 8233, 8235, 8263, 8264, 8265, 8288, 8304, 8350, 8380, 8381, 8393, 8500, 8745
8	**SERVICE:** 0917, 2585, 2586, 2587, 2589, 4362, 5191, 5192, 6836, 7360, 7610, 8279, 8291, 8292, 8293, 8392, 8601, 8720, 8800, 8824, 8825, 8826, 8829, 8831, 8832, 8833, 8835, 8861, 8868, 8869, 8989, 9012, 9014, 9015, 9016, 9019, 9033, 9040, 9044, 9052, 9058, 9059, 9060, 9061, 9062, 9063, 9082, 9083, 9084, 9089, 9093, 9101, 9102, 9110, 9154, 9156, 9178, 9179, 9180, 9182, 9186, 9220, 9516, 9519, 9521, 9586, 9600, 9620
9	**HIGH RISK COMMERCIAL/SERVICE:** 4511, 4777, 7590, 7704, 7720, 7772, 8606, 9088, 9402, 9403, 9984, 9985
10	**OFFICE WORK/MISCELLANEOUS:** 8721, 8742, 8748, 8755, 8803, 8810, 8820, 8871

APPENDIX C
TABLE 1
Part C

Industry Group
(LLR)

Credibility Group	1	2	3	4	5	6	7	8	9	10
1	0.3925	0.3208	0.3924	0.3095	0.2996	0.3442	0.3685	0.3823	0.3289	0.3499
2	0.3925	0.3208	0.3924	03095	0.2996	0.3442	0.3685	0.3823	0.3289	0.3499
3	0.5216	0.4476	0.5327	0.4407	0.4333	0.4814	0.5083	0.5303	0.4727	0.4890
4	0.6071	0.5410	0.6278	0.5353	0.5290	0.5799	0.6055	0.6319	0.5735	0.5860
5	0.6936	0.6313	0.7214	0.6348	0.6297	0.6867	0.7024	0.7300	0.6706	0.6836
6	0.7628	0.7095	0.7930	0.7168	0.7144	0.7650	0.7770	0.8037	0.7467	0.7610
7	0.7963	0.7488	0.8265	0.7566	0.7569	0.7992	0.8123	0.8379	0.7841	0.7982
8	0.8234	0.7827	0.8544	0.7906	0.7930	0.8271	0.8416	0.8662	0.8166	0.8294
9	0.8471	0.8122	0.8780	0.8203	0.8241	0.8519	0.8669	0.8897	0.8485	0.8555
10	0.8682	0.8397	0.8984	0.8470	0.8519	0.8730	0.8888	0.9098	0.8688	0.8777
11	0.8882	0.8650	0.9162	0.8708	0.8764	0.8918	0.9078	0.9270	0.8900	0.8973
12	0.9068	0.8878	0.9315	0.8922	0.8986	0.9087	0.9241	0.9415	0.9085	0.9149
13	0.9239	0.9084	0.9449	0.9114	0.9179	0.9230	0.9385	0.9537	0.9248	0.9305
14	0.9394	0.9265	0.9565	0.9286	0.9347	0.9357	0.9510	0.9640	0.9395	0.9445
15	0.9535	0.9428	0.9667	0.9440	0.9495	0.9484	0.9618	0.9727	0.9530	0.9569
16	0.9656	0.9572	0.9755	0.9578	0.9624	0.9611	0.9713	0.9800	0.9644	0.9680
17	0.9761	0.9696	0.9830	0.9699	0.9737	0.9729	0.9799	0.9861	0.9744	0.9775
18	0.9852	0.9802	0.9895	0.9809	0.9835	0.9830	0.9875	0.9914	0.9837	0.9855
19	0.9934	0.9902	0.9951	0.9910	0.9922	0.9916	0.9942	0.9960	0.9925	0.9930
20	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000

Revised 7-1-2002

Disabled Workers' Relief Fund Rates to Cover Injury Prior to January 1, 1987

Rates are for each $100 unit of payroll and are effective January 1, 1980.

Private employers $0.10

Public employer taxing districts $0.10

Public employer state agencies $0.10*

*Effective July 1, 1980, for public employer state agencies.

Additional Disabled Workers' Relief Fund Rates to Cover Injuries on and after January 1, 1987

Rates are percent of premium computed at basic rate and are effective July 1, 1993.

Private employers ..... 0.10 %

Public employer taxing districts ..... 0.10 %*

Public employer state agencies ..... 0.10 %

* Effective January 1, 1993, for public employer taxing districts.

Administrative Cost Rates

Rates are a percentage of premium and are effective according to the dates below.

Private employers:	19.50 per cent of premium effective July 1, 2002.
Public employer taxing districts:	16.65 per cent of premium effective January 1, 2002.
Public employer state agencies:	21.91 per cent of premium effective July 1, 2002.

Marine Industry Fund Rates
Effective July 1, 2001

Rates are for each $100 unit of payroll

NCCI Manual Code	Manual Rate
6802	$ 21.10
6847	40.48
7310	19.57
7325	53.04
7330	21.10
8707	53.04
8708	13.49

NOTE: Manual descriptions for the classifications are in the NCCI Classification section of this publication that begins on page 120.

Ohio's underwriting coverage of these manuals is subject to approval by the Federal Government.

Coal-Workers Pneumoconiosis Fund Rates
Effective July 1, 2001

Rates are for each $100 unit of payroll

NCCI Manual Code	Manual Rate
1112	$ 3.70
1115	1.07
1116	0.83

NOTE: The above premium rates shall apply only to employers who newly subscribe to the coal-workers pneumoconiosis fund on or after May 15, 1998. The bureau shall institute a moratorium on premium collections from all employers who were subscribers to the coal workers pneumoconiosis fund prior to May 15, 1998, and who remain subscribers to the fund.

NOTE: Manual descriptions for the classifications are in the NCCI Classifications section of this publication that begins on page 120.

Ohio's underwriting coverage of these manuals is subject to approval by the Federal Government.

BWC
NCCI Classification Base Rates
and Expected Loss Rates
Effective July 1, 2002

Base Rates and Expected Loss Rates are for each $100 Unit of Payroll
Rates Do Not Include Administrative Cost, DWRF, or Additional DWRF Assessments

Manual Code	Base Rate	Expected Loss Rate	Manual Code	Base Rate	Expected Loss Rate	Manual Code	Base Rate	Expected Loss Rate
0005	$9.16	$1.95	2002	$7.77	$3.16	2576	$7.69	$2.80
0008	$8.36	$1.87	2003	$9.82	$3.45	2578	$9.54	$2.14
0016	$14.70	$2.81	2014	$8.13	$3.29	2585	$7.29	$3.17
0034	$9.08	$3.29	2016	$15.21	$6.58	2586	$5.67	$2.27
0035	$6.64	$2.18	2021	$3.35	$0.43	2587	$4.66	$3.72
0036	$16.74	$3.06	2039	$13.75	$4.30	2589	$2.78	$1.07
0037	$15.27	$3.31	2041	$10.73	$4.13	2600	$5.84	$0.00
0042	$12.97	$3.55	2065	$4.25	$1.22	2623	$7.70	$4.45
0050	$14.77	$6.15	2070	$8.13	$3.57	2651	$6.44	$2.38
0079	$13.13	$2.51	2081	$13.96	$4.41	2660	$11.67	$7.54
0083	$13.04	$2.53	2089	$19.90	$6.07	2670	$3.98	$2.53
0106	$49.12	$12.53	2095	$7.04	$3.04	2683	$6.89	$0.95
0113	$5.43	$3.93	2105	$8.08	$4.76	2688	$2.09	$0.55
0170	$10.93	$1.00	2110	$9.45	$3.69	2702	$41.06	$9.70
0251	$6.28	$0.67	2111	$6.05	$2.10	2710	$31.10	$7.10
0400	$3.63	$1.42	2112	$3.62	$2.23	2714	$5.31	$2.90
0401	$5.15	$1.42	2114	$5.17	$2.08	2731	$15.63	$4.82
0917	$12.83	$3.85	2121	$5.37	$2.39	2735	$6.24	$1.31
1005	$6.47	$1.98	2130	$2.76	$2.43	2759	$11.26	$3.86
1016	$9.06	$1.61	2131	$2.17	$1.21	2790	$6.14	$2.56
1164	$25.48	$1.20	2143	$2.85	$1.79	2802	$9.37	$3.55
1165	$5.25	$8.62	2150	$27.13	$5.06	2812	$8.21	$2.42
1320	$6.73	$1.84	2156	$5.22	$1.91	2835	$4.12	$3.68
1322	$12.81	$0.70	2157	$6.71	$3.34	2836	$6.84	$3.86
1430	$18.12	$9.89	2172	$4.50	$0.90	2841	$13.58	$2.92
1438	$15.15	$5.45	2174	$17.30	$17.50	2881	$4.52	$1.14
1452	$15.11	$57.94	2211	$3.64	$0.57	2883	$8.12	$2.74
1463	$12.86	$3.75	2220	$8.13	$3.25	2913	$7.98	$6.92
1472	$6.25	$2.96	2286	$13.90	$0.46	2915	$4.00	$2.55
1624	$8.63	$2.63	2288	$4.65	$2.42	2916	$8.01	$3.25
1642	$1.30	$0.33	2300	$5.17	$2.08	2923	$1.34	$0.45
1654	$3.98	$3.17	2302	$8.60	$4.76	2942	$6.38	$25.13
1655	$3.98	$0.02	2305	$8.24	$4.64	2960	$16.95	$4.86
1699	$12.40	$5.32	2361	$10.54	$0.02	3004	$6.37	$3.87
1701	$7.05	$2.98	2362	$5.45	$5.25	3018	$7.58	$4.17
1710	$13.70	$3.95	2380	$2.04	$1.06	3022	$7.07	$2.78
1741	$7.17	$3.97	2386	$5.12	$0.00	3027	$3.29	$1.37
1747	$9.37	$3.04	2388	$4.30	$0.80	3028	$6.28	$2.99
1748	$9.17	$5.10	2402	$4.45	$1.09	3030	$16.93	$5.59
1803	$12.04	$4.55	2413	$4.48	$1.45	3040	$8.55	$3.37
1852	$26.53	$2.08	2416	$5.52	$0.02	3041	$10.35	$2.26
1853	$16.30	$1.67	2417	$8.39	$0.35	3042	$6.15	$2.26
1860	$5.96	$2.33	2501	$5.16	$1.93	3064	$5.11	$1.57
1924	$11.84	$1.75	2503	$2.06	$0.03	3066	$10.89	$3.75
1925	$9.15	$2.79	2534	$9.28	$5.76	3076	$4.78	$2.03
2001	$4.21	$1.73	2570	$7.71	$3.20	3081	$8.00	$4.03

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3082	$28.11	$8.15	3612	$3.58	$1.48	4206	$5.17	$2.08
3085	$10.38	$3.73	3620	$8.05	$2.37	4207	$20.55	$15.37
3110	$9.65	$4.11	3629	$1.46	$0.52	4239	$5.52	$2.57
3111	$7.68	$2.54	3632	$4.61	$1.62	4240	$5.94	$2.71
3113	$4.38	$1.29	3634	$2.00	$0.84	4243	$4.43	$2.37
3114	$5.79	$2.14	3635	$2.16	$1.12	4244	$4.29	$1.80
3118	$2.05	$1.06	3638	$2.59	$1.89	4250	$3.86	$2.08
3119	$5.17	$2.08	3642	$3.44	$0.83	4251	$3.82	$1.51
3122	$6.21	$2.74	3643	$3.59	$1.50	4263	$6.67	$3.47
3126	$3.41	$0.99	3647	$2.95	$1.37	4273	$5.38	$1.88
3131	$2.86	$0.42	3648	$2.93	$1.28	4279	$6.59	$2.61
3132	$4.71	$1.86	3681	$3.05	$1.16	4282	$5.17	$2.08
3145	$3.69	$1.52	3685	$2.72	$0.89	4283	$2.74	$1.14
3146	$3.47	$1.73	3719	$3.72	$0.57	4299	$3.52	$1.20
3169	$3.88	$1.73	3724	$12.87	$4.15	4304	$5.11	$2.08
3175	$3.08	$0.00	3726	$6.05	$2.07	4307	$4.88	$1.61
3179	$2.78	$1.39	3803	$1.93	$0.59	4308	$5.17	$2.08
3180	$7.64	$3.73	3807	$8.44	$3.89	4351	$1.52	$0.00
3188	$4.66	$2.41	3808	$7.22	$3.73	4352	$1.76	$0.77
3220	$5.16	$2.72	3821	$12.96	$4.23	4360	$3.27	$0.01
3223	$3.64	$0.00	3822	$7.50	$3.07	4361	$1.30	$0.53
3224	$6.71	$3.51	3824	$7.20	$3.15	4362	$8.24	$5.32
3227	$4.65	$2.63	3826	$1.99	$0.96	4410	$5.00	$2.14
3240	$8.33	$2.14	3827	$1.60	$0.94	4420	$6.23	$3.13
3241	$8.73	$4.03	3830	$1.40	$0.72	4431	$5.17	$2.08
3255	$6.21	$4.60	3851	$19.06	$0.03	4432	$4.85	$0.65
3257	$4.83	$2.25	3865	$3.94	$1.17	4439	$5.25	$17.51
3270	$7.81	$0.38	3881	$7.22	$4.32	4452	$5.61	$2.18
3300	$3.99	$2.14	4000	$7.85	$2.09	4459	$4.80	$1.99
3303	$4.01	$1.99	4021	$6.37	$3.24	4470	$5.61	$1.89
3307	$5.96	$2.57	4024	$10.26	$3.57	4484	$5.02	$2.27
3315	$8.21	$2.12	4034	$9.42	$3.67	4493	$7.49	$4.30
3334	$3.14	$0.00	4036	$3.46	$1.81	4511	$1.73	$0.59
3336	$6.43	$1.91	4038	$1.67	$0.55	4557	$2.99	$1.30
3365	$12.97	$4.09	4053	$14.58	$7.81	4558	$3.20	$1.66
3372	$5.27	$1.84	4061	$7.33	$2.85	4561	$10.27	$5.80
3373	$2.87	$1.28	4062	$4.07	$2.26	4568	$1.58	$10.18
3383	$1.92	$1.17	4101	$9.63	$3.18	4581	$5.17	$2.08
3385	$1.80	$0.07	4111	$10.26	$1.37	4583	$5.83	$2.71
3400	$5.47	$2.56	4112	$3.16	$3.13	4611	$1.69	$0.50
3507	$4.48	$1.65	4113	$7.64	$3.23	4635	$3.58	$2.03
3515	$10.44	$0.08	4114	$8.97	$1.41	4653	$3.45	$2.22
3548	$2.80	$0.72	4130	$6.98	$2.78	4665	$10.03	$4.03
3559	$5.66	$1.54	4131	$5.63	$1.23	4670	$5.17	$2.08
3574	$2.29	$0.87	4133	$5.29	$1.07	4683	$1.54	$0.03
3581	$1.91	$0.54	4150	$2.24	$0.92	4686	$9.05	$2.31

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4692	$1.68	$0.25	5480	$4.18	$1.37	6884	$4.46	$0.00
4693	$1.87	$0.70	5491	$30.29	$1.31	7133	$1.69	$0.46
4703	$5.10	$0.00	5506	$6.18	$2.60	7219	N/A	$3.87
4717	$4.50	$0.83	5507	$4.56	$1.49	7222	$27.22	$3.44
4720	$3.95	$1.71	5508	$15.61	$10.09	7228	$13.40	$4.26
4740	$6.83	$3.77	5536	$3.94	$1.54	7229	$8.07	$3.26
4741	$6.77	$4.49	5537	$6.69	$2.05	7230	$5.79	$3.07
4751	$4.27	$1.95	5538	$7.40	$2.80	7231	$13.52	$5.88
4771	$2.89	$1.88	5551	$19.90	$5.31	7232	$9.14	$3.65
4777	$10.75	$10.17	5605	$4.02	$1.90	7360	$11.56	$5.93
4825	$1.44	$0.39	5606	$2.93	$0.83	7370	$8.40	$3.89
4828	$2.83	$1.37	5610	$17.61	$5.06	7380	$8.87	$3.81
4829	$1.65	$0.65	5645	$12.28	$3.29	7382	$7.15	$4.14
4902	$5.68	$2.70	5651	$5.51	$1.81	7390	$6.40	$3.50
4923	$1.53	$0.64	5703	$7.60	$1.93	7403	$2.78	$1.22
5020	$11.73	$4.15	5705	$32.63	$33.21	7405	$1.28	$0.52
5022	$10.48	$3.51	5951	$5.17	$2.08	7409	$9.26	$0.11
5037	$54.28	$20.87	6003	$23.07	$12.78	7420	$2.02	$0.08
5040	$24.10	$8.13	6005	$8.58	$1.94	7421	$4.39	$1.50
5057	$15.03	$4.97	6017	$8.74	$0.00	7422	$1.86	$0.69
5059	$18.07	$6.99	6018	$8.74	$0.00	7423	$3.85	$1.80
5069	$40.72	$ 15.86	6045	$8.21	$2.73	7425	$3.23	$0.43
5102	$8.41	$3.21	6204	$13.71	$3.76	7431	$1.51	$0.14
5146	$5.52	$2.19	6206	$19.25	$0.09	7502	$1.06	$0.15
5160	$3.99	$2.05	6213	$6.37	$0.00	7515	$4.70	$2.23
5183	$5.82	$1.95	6214	$10.06	$0.09	7520	$3.36	$1.34
5188	$4.97	$1.79	6216	$8.97	$3.53	7538	$13.27	$4.77
5190	$5.03	$1.67	6217	$7.69	$2.52	7539	$2.36	$1.31
5191	$1.44	$0.48	6229	$8.52	$2.93	7540	$3.85	$1.65
5192	$7.16	$2.33	6233	$5.54	$2.09	7580	$6.43	$2.97
5213	$11.70	$3.58	6235	$23.47	$9.57	7590	$5.91	$2.49
5215	$20.67	$5.35	6236	$5.36	$0.00	7600	$1.77	$0.94
5221	$9.13	$2.84	6237	$1.87	$0.13	7601	$5.86	$2.82
5222	$5.90	$3.41	6251	$8.65	$3.83	7605	$3.40	$1.22
5223	$10.61	$3.33	6252	$2.35	$1.39	7610	$0.42	$0.13
5348	$7.94	$2.50	6260	$34.58	$5.44	7611	$4.16	$2.89
5402	$26.09	$5.82	6306	$3.29	$1.70	7612	$3.57	$1.61
5403	$8.84	$2.57	6319	$4.21	$2.22	7613	$7.19	$3.56
5437	$10.98	$2.70	6325	$12.36	$4.52	7704	$40.99	$9.98
5443	$22.83	$11.76	6400	$12.27	$3.56	7720	$3.99	$1.79
5445	$7.68	$2.83	6504	$4.34	$1.93	7772	$3.00	$1.92
5462	$9.13	$2.69	6704	$8.63	$3.44	7855	$7.33	$3.86
5472	$19.22	$4.70	6811	$3.66	$0.00	8001	$2.88	$0.98
5473	$12.45	$5.33	6834	$4.80	$1.22	8002	$4.63	$1.97
5474	$13.79	$3.72	6836	$7.77	$3.49	8006	$4.07	$1.78
5478	$8.68	$2.69	6854	$10.27	$39.86	8008	$1.66	$0.76
5479	$11.36	$4.67	6882	$3.64	$0.00	8010	$3.45	$1.44

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8013	$0.64	$0.22	8500	$9.33	$3.32	9089	$1.66	$0.07
8015	$1.42	$0.55	8601	$0.59	$0.18	9093	$2.66	$0.80
8017	$2.33	$1.07	8606	$11.14	$3.32	9101	$1.09	$0.37
8018	$3.62	$1.55	8720	$1.73	$0.73	9102	$5.12	$1.59
8021	$5.28	$2.75	8721	$1.37	$0.54	9110	$2.45	$1.25
8031	$4.76	$1.70	8742	$0.70	$0.24	9154	$3.05	$1.17
8032	$2.81	$1.33	8745	$4.60	$3.32	9156	$2.24	$0.98
8033	$3.55	$1.43	8748	$0.50	$0.13	9178	$22.18	$10.57
8039	$4.19	$4.23	8755	$0.42	$0.30	9179	$23.50	$10.69
8044	$4.90	$1.93	8800	$1.40	$0.66	9180	$8.42	$3.27
8045	$1.30	$0.38	8803	$0.19	$0.06	9182	$3.34	$1.50
8046	$2.98	$1.27	8810	$0.41	$0.15	9186	$19.94	$8.01
8047	$7.42	$1.27	8820	$0.36	$0.10	9220	$6.10	$2.40
8050	$7.29	$0.09	8824	$5.14	$2.63	9402	$8.60	$2.87
8058	$4.32	$1.46	8825	$3.64	$1.59	9403	$6.46	$4.01
8072	$1.19	$0.52	8826	$2.38	$1.11	9501	$5.12	$1.94
8102	$2.04	$0.35	8829	$4.87	$2.25	9505	$5.28	$0.60
8103	$15.05	$0.68	8831	$2.77	$0.71	9516	$2.44	$0.83
8105	$8.27	$7.41	8832	$0.47	$0.16	9519	$6.62	$2.02
8106	$6.45	$2.99	8833	$1.21	$0.66	9521	$7.64	$1.75
8107	$4.12	$1.49	8835	$6.21	$2.83	9522	$3.01	$1.73
8111	$4.72	$1.85	8861	$2.64	$1.00	9534	$1.96	$0.97
8116	$4.32	$0.77	8868	$0.55	$0.20	9554	$5.47	$2.95
8203	$4.15	$2.56	8869	$1.17	$0.67	9586	$0.91	$0.42
8204	$5.33	$3.17	8871	$0.59	$0.23	9600	$1.85	$0.04
8209	$4.93	$2.01	8901	$0.15	$0.05	9620	$2.60	$0.46
8215	$4.03	$1.29	8989	$2.67	$1.38	9984	$1.22	$0.30
8227	$6.67	$2.97	9012	$1.26	$0.42	9985	$3.82	$1.68
8232	$6.00	$2.47	9014	$4.27	$1.93			
8233	$3.44	$2.54	9015	$4.61	$1.79			
8235	$4.95	$1.73	9016	$2.62	$1.25			
8263	$11.06	$4.19	9019	$6.52	$0.00			
8264	$8.79	$2.58	9033	$2.05	$1.07			
8265	$10.88	$3.59	9040	$2.15	$1.04			
8279	$12.87	$4.59	9044	$2.57	$0.93			
8288	$4.07	$1.07	9052	$4.52	$1.94			
8291	$5.00	$2.98	9058	$2.82	$1.23			
8292	$5.06	$2.92	9059	$1.65	$0.60			
8293	$12.71	$4.60	9060	$3.36	$0.98			
8304	$3.51	$1.72	9061	$2.85	$1.18			
8350	$5.57	$1.98	9062	$1.94	$1.22			
8380	$4.93	$1.44	9063	$2.03	$0.59			
8381	$2.27	$0.93	9082	$3.07	$1.20			
8385	$2.35	$1.14	9083	$3.17	$1.31			
8392	$3.37	$1.76	9084	$3.51	$1.21			
8393	$3.81	$1.20	9088	$3.82	$1.68			